H.R. 901 AND H.R. 1199, AND OTHER HEALTH CARE INITIATIVES

HEARING

BEFORE THE

SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

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H.R. 901, H.R. 1199, AND OTHER HEALTH CARE INITIATIVES

Wednesday, April 12, 1989

House of Representatives,
Subcommittee on Hospitals and Health Care,
Committee on Veterans' Affairs,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9 a.m., in room 334, Cannon House Office Building, Hon. G.V. (Sonny) Montgomery (chairman of the subcommittee) presiding.

Present: Representatives Montgomery, Hammerschmidt, Rowland of Georgia, Stump, McEwen, Stenholm, Burton, Harris, Bilirakis, Kennedy, Rowland of Connecticut, Johnson, Jontz, Payne, and Morrison.

Also present: Representative Staggers.

OPENING STATEMENT OF CHAIRMAN MONTGOMERY

Mr. Montgomery. The Subcommittee on Hospitals and Health Care will come to order.

Veterans' health care is now at a critical juncture. Our funding crisis has been well documented and publicized. This will work to our advantage, we hope, in acquiring the additional funding we need so badly to run these veterans' hospitals in a proper manner.

As you may know, President Bush has recommended a supplemental VA medical care appropriation to the Hill. Last week, the Subcommittee on VA, HUD, and Independent Agencies of the Appropriations Committee recommended a $340 million medical care supplemental for this fiscal year to the full Appropriations Committee. Hopefully, this will be sent to the House floor by the end of this month. But even if the supplemental is okayed, we still have to be concerned about next year to get enough money to run these veterans' hospitals.

Health care programs are being terminated, services are being eliminated, beds are being closed, health care professionals are choosing to go into the private sector over the VA, and across the country veterans are being denied medical care. Left unchecked—and I've said this before—this situation would likely lead to the closing of some VA hospitals unless we get more funds.

The decisions we make in the next few months will be some of the most important this committee and the Congress will ever make. The future of VA medical care lies in the options we will choose during the 101st Congress. It lies in more than just our pursuit of adequate funding. We must address other shortcomings in the system as well. We must proceed with care. We cannot accept unnecessary delays. Our system is in trouble, and we must respond quickly.

Today we respond to a people problem, the recruitment and retention of health care professionals, particularly nurses. The legislation we will consider this morning is crucial to our effort to maintain quality care within the VA and to restore services to a level adequate to treat all eligible veterans.

As we are all aware, and as testimony in recent hearings has shown, there is a real shortage of nursing personnel. Two bills, H.R. 901 and H.R. 1199, address the issue in the form of nurses' pay. H.R. 901 offers both primary pay and incentive special pay in order to enhance recruitment and retention of nurses. H.R. 1199 would provide greater flexibility in the nurse pay system through pay bands rather than a wage ladder, like the system currently uses for other Federal employees.

H.R. 901 extends some expiring programs. It would continue the State Home Grant Program for 3 years—this is our State nursing program—for 3 years, or until September 30, 1992. It would make permanent the VA program for respite care. H.R. 901 also contains provisions containing the homeless veterans' program and the compensated work therapy program.

Additionally, H.R. 901 deals with health care management. It calls for the Secretary of Veterans' Affairs to establish a pilot program to improve the collection of health insurance for VA care provided to non-service-connected disability veterans. In part, this program would employ automation to carry out the billing and collection actions. We previously have authorized these collections, but we haven't done a very good job in collecting, and I think Mr. Staggers from West Virginia will talk about that.

Other issues are: authority to provide DOD dependents health care in Department of Veterans Affairs medical facilities on a space-available basis with the VA and DOD sharing agreements. This is an amendment I pushed last year. Where there are beds available in VA health care hospitals, dependents of medical personnel could use those beds on an agreement between the DOD and the VA. We will also hear testimony on the ordering of prosthetics and prosthetic services.

Before each Member are copies of the bills as well as a summary of the two bills I have just talked about.

[The bills and summaries appears at pp. 49 and 66.]

Mr. MONTGOMERY. As you can see, we have a full schedule this morning. The Vietnam Veterans of America and AMVETS, without objection, would like to submit a statement and not testify this morning.

[The statements of the Vietnam Veterans of America and AMVETS appear at pp. 172 and 178.]

Mr. MONTGOMERY. Now the chair would like to recognize the ranking minority member, a great friend of the veteran, John Paul Hammerschmidt.

OPENING STATEMENT OF HON. JOHN PAUL HAMMERSCHMIDT

Mr. HAMMERSCHMIDT. Thank you very much, Mr. Chairman.

I am certainly pleased to join you and our ranking member, Mr. Stump, and other members of the committee today to hear testimony on a number of important issues affecting the health care of our Nation's veterans.

Mr. Chairman, you have highlighted for us the major provisions of H.R. 901, H.R. 1199, and the draft bill that we have before us. It is important to also point out that many of these same provisions were favorably reported out of this subcommittee and the full committee and were passed by the entire House in the second session of the 100th Congress, but we were unable to reach agreement with our counterparts in the Senate, so we are considering these important provisions once again.

Mr. Chairman, perhaps one of the most perplexing problems being faced by the Department of Veterans Affairs and, in fact, by the Nation is the nursing shortage. The Committee on Veterans' Affairs has held previous hearings on the national nursing shortage and the effect it is having on the health care provided to America's veterans.

We have all agreed that the VA in indeed experiencing difficulties in its ability to recruit and retain professional nurses, and now the time has come to send legislation to the President. One thing is certain: VA nurses are an essential component of the health care we must render the veterans, and therefore we must address the fact that the VA has a nurse attrition rate of approximately 26.5 percent per year.

H.R. 901 and H.R. 1199 both address the nursing shortage, but each takes a different approach. It is important to hear what all of the witnesses think. These are the people out here who know what is best, because they represent the VA collectively. They are the providers and the consumers of health care in the VA.

The other provisions of the bills pertaining to various health care initiatives, improvements, and program extensions have been explained by our distinguished chairman. Each provision is the result of careful deliberation. I want to state my strong support for these provisions and rapid relief of the VA's nursing personnel crisis.

So, Mr. Chairman, I am looking forward to hearing the witnesses and the testimony of today.

Thank you.

Mr. **Montgomery**. Thank you.

Bob Stump, as the ranking minority member, do you have any comments?

Mr. **Stump**. No, thank you, Mr. Chairman.

Mr. **Montgomery**. Harley Staggers is our first witness today. He is a Member of Congress, as we all know, from the Second District of West Virginia. He serves on this committee, and he is chairman of the Subcommittee on Housing and Memorial Affairs.

Before hearing from Harley, Mr. Burton of Indiana.

Mr. **Burton**. Thank you, Mr. Chairman.

I have a statement I would like to submit for the record.

Mr. **Montgomery**. Without objection, it is so ordered.

Mr. **Burton**. But I have one statement I would like to make, and that is, there is a practical problem with nurses' salaries and the availability of nurses for the various hospitals around the country. In my district in Indiana, in the Roudebush Hospital, there have been two wards closed down because of lack of nurses. Now so far, no veterans have been turned away from that facility, but the fact of the matter is, that is a very real possibility in the future.

So I am very happy you are holding this hearing today on this legislation, because I think it is extremely important long range that we make sure we have an adequate number of nurses available at these facilities. We are going to have to compensate them properly. Otherwise, in the future, veterans are going to be turned away.

I thank the chairman for yielding.

[The prepared statement of Congressman Burton appears at p. 77.]

Mr. **Hammerschmidt**. Would the gentleman from Indiana yield?

Mr. **Burton**. Yes, I'll be happy to yield to my colleague.

Mr. **Hammerschmidt**. I just want to recognize Dan, who is the newest member of this subcommittee. He is a long-term member of the committee.

We are glad that you are aboard.

Mr. **Burton**. Thank you, sir.

Mr. **Hammerschmidt**. While I have the floor, Mr. Chairman, I would like to ask that Chris Smith and Bob McEwen be allowed to submit a statement for the record.

Mr. **Montgomery**. Without objection.

[The statements of Congressman Smith and Congressman McEwen appear at pp. 78 and 80.]

Mr. **Montgomery**. I might say that we sent a very good health care bill to the Senate last year. It had Joe Kennedy's amendment, two very fine incentives for nurses. This was knocked out in conference, and I hope again this year to send as good a bill as we did last year.

Mr. Kennedy.

Mr. **Kennedy**. Mr. Chairman, I have a statement that I would like to read for the record, please.

Mr. **Montgomery**. You want to read it, or you want to put it in there?

Mr. **Kennedy**. Yes.

Mr. **Montgomery**. Okay. Read it.

OPENING STATEMENT OF HON. JOSEPH P. KENNEDY, II

Mr. **Kennedy**. I'm sorry, Mr. Chairman. Today, I want to read it. Thank you.

As members of this committee, we have listened to hours and hours of testimony about the terrible crisis facing the Veterans' Administration medical centers. We have listened to accounts of medical centers closing patient wards, denying care to war-injured veterans and cutting back on essential patient services. We have seen the VA testify in this hearing room, and, frankly, I think we have all grown tired of hearing the denials of these accounts, denials that the Department is grossly underfunded, and denials that the severe underfunding impedes their ability to hire nurses which would allow them to reopen closed wards. They also would deny that they have stopped admitting deserving veterans and that they need to restore patient services.

The inability to attract registered nurses is one of the root causes of the VA medical crisis, and the inability to pay nurses on a competitive basis with the private sector, without a doubt, is the root cause of the VA nursing shortage.

Mr. Chairman, last week the Washington Post came out with a series of articles on a report recently issued by the National Commission on Public Service, which became known as the Volcker Report.

The proposals promulgated by this respected Commission were aimed at preventing the Federal Government from becoming an employer which hires the mediocre. These proposals included replacing the nationwide General Schedule with a system of base pay which compensates for the living costs and giving local managers greater flexibility in making decisions.

This March, I introduced legislation with several of my colleagues on this committee—Tom Ridge, John Rowland, Lane Evans, Tommy Robinson, Jim Florio, and Harley Staggers—which builds on many of the recommendations of this report. H.R. 1199, the Veteran's Nurse Pay Act, replaces the present pay schedule with a new schedule and gives the local director flexibility in hiring practices. The hospital director will be able to provide salaries within a broad range, taking into account local labor market needs and the cost of living without prior VA central office approval.

There are many problems associated with the present pay system; 75 percent of the VA hospitals now need special salaries over and above what the General Schedule provides; many hospital directors must wait several months in order to receive approval for special salary rates, and in many areas, special salary rates are no longer competitive. By giving the hospital directors the flexibility to establish salaries, H.R. 1199 will address these problems.

This legislation also provides nurses with the incentive to excel in their practice by rewarding them for assuming head nurse positions, publishing professional articles, and attaining clinical certification.

Mr. Chairman, there was a time when the VA hospitals attracted the best, but after decades of budget cuts and pay freezes we are now looking at a medical system which has 2,400 RN vacancies due to recruitment problems. The VA cannot afford to become an employer of the mediocre. There are too many lives that depend on this day-to-day delivery system of quality health care by a competent professional nurse.

I support the nursing provisions in the chairman's bill, H.R. 901, that were introduced by the chairman. The two proposals that we are hearing testimony on today are aimed at abating the nursing crisis.

I look forward to hearing from our expert witnesses so that we can determine how we can best re-establish the VA as a competitive employer.

Thank you very much, Mr. Chairman.

Mr. MONTGOMERY. Thank you, Joe.

The Chair will go back and forth, and, Harley, we will get to you in just a few minutes here.

Mr. Bilirakis, do you have a statement?

Mr. **Bilirakis**. Thank you, Mr. Chairman.

The agenda is a long one, sir, and I realize we don't want to take too much time on these, and I don't have a formal statement, but just in my own words, I think it is important to make an observation.

We all know that there is a shortage of nurses, not only as far as the VA is concerned but in general; we know that. The important thing is to find out why, and I am hopeful that our committee today will concentrate on things like burn-out, methods of recruiting, why there is an attrition of nurses, what the reasons are, and things of that nature. If we get answers to those questions, then we are probably going to get the answer to the overall nurse shortage, and I do commend you, sir, for concentrating on this subject.

Thank you.

Mr. **Montgomery**. Thank you.

The Chair would like to introduce not a new Member to Congress but a new member on our Veterans' Affairs Committee, a new member on the hospital subcommittee, Bruce Morrison of Connecticut.

Bruce, we are glad to have you on the subcommittee.

Mr. **Morrison**. Thank you, Mr. Chairman.

Mr. Chairman, thank you for scheduling this hearing and focusing the attention of the subcommittee and the full committee on the critical issues relating to the supply of well trained, well qualified nurses in our VA medical centers.

Certainly in Connecticut, we have experienced severe problems in recruitment and retention. We have made use of special pay provisions, but the problems persist. So the subjects that are before us today are very important ones.

I would also urge that the subcommittee keep in mind that one of the problems in the area of nursing personnel generally, not just in the VA system, is the lack of adequate recruitment and training of nursing assistants and licensed practical nurses who provide a potential source of staffing that is not being exploited to the extent possible.

We have had the advantage recently in Connecticut of a new program being created at the West Haven Veterans' Administration Medical Center for in-grade training and upgrading of skills and the opportunity for these individuals to advance. I think that this is also an important part of our consideration, because I think job opportunities for people who enter the service at the nursing assistant level can help to deal with our shortage and give those individuals advancement opportunities as well as creating a larger pool of people from which we can draw nurses in our service, and I would hope that the subcommittee might have an opportunity to look into those questions in the course of its investigation, and I thank you, Mr. Chairman.

Mr. **Montgomery**. Thank you.

We have Dr. Gronvall and others representing the VA who certainly can answer some questions this morning.

Dr. Rowland, do you want to make a comment?

Dr. **Rowland of Georgia**. Yes, thank you, Mr. Chairman.

Mr. Chairman, the issues that we will be discussing here this morning range across the spectrum of VA care from nurse recruitment to the improvement of the delivery of prosthetic services to the collection of reimbursement from third-party payers. Yet all of these issues relate to maintaining quality care for the veterans in our country in the most effective way.

The VA's strong affiliations with our Nation's medical schools and our schools of nursing and schools of other health professions have provided nearly 40 years of state-of-the-art medical care.

VA medical care is consistently among the best available. The successes in research, as seen in contributions to new knowledge in heart and liver disease and recognition through Nobel and other prizes, are further evidence of the quality of VA care. But there is always the nagging question of what is the cost of such premier quality.

There has been considerable talk, especially during the last few months, about the budget shortfalls of the VA medical care system. It is not surprising, I suppose, that there have also been questions about the cost of providing VA care. There are not yet equivocal data showing the VA is providing care in a less costly fashion than providers under Medicare, but there is growing evidence that that is true.

During the last 10 years, the VA budget has been straight line, yet the number of in-patients treated has increased by 7 percent, the number of out-patients by 29 percent, and the number of long-term-care patients by 60 percent. It would be great if Medicare could match this track record of the VA with regard to the cost of care.

So I think, Mr. Chairman, that it is important that we consider all of the proposals today that we think about in maintaining the quality of care that is the mark of this Department and continue the efficient use of resources that distinguish it, and I look forward to the testimony this morning.

Thank you, Mr. Chairman.

Mr. MONTGOMERY. Thank you, Dr. Rowland.

You pointed out that you had been involved in private hospitals in civilian life before you came to Congress. As far as inflation is concerned, the VA has had an inflation factor increase of 3 or 4 percent across the board when, in private hospital care, the rate has been over 10 percent. Is that correct?

Dr. ROWLAND OF GEORGIA. That is correct, Mr. Chairman, and isn't it surprising to you that with the straight line that we have had in hospital and health care in the VA we have seen these significant increases in the number of patients that have been treated and yet have not increased the cost nearly in proportion to what Medicare has done over the past several years.

Mr. MONTGOMERY. Thank you.

Harley Staggers, I'm sorry to delay you and am very glad to have you testify this morning as a member of this committee.

STATEMENT OF HON. HARLEY O. STAGGERS, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WEST VIRGINIA

Mr. STAGGERS. Thank you, Mr. Chairman.

I want to compliment you first for holding the hearings about the need to improve the veterans' health care system. In my first three terms of Congress, I did serve on this subcommittee, and I miss it, so I had to come back at least once and testify.

I want to compliment Joe Kennedy also with his bill to establish a more stable system of compensation for registered nurses. It does correct a fundamental problem with the pay system and makes a more sound approach. It doesn't address all the components for health care providers, but it is a very important step, and I hope that this subcommittee would give it very favorable consideration.

I also want to compliment you for H.R. 901, Mr. Chairman, the comprehensive bill designed to address a number of critical issues facing the VA. I think it is such a good idea that we should do it all now, and that is where I would differ.

I do have legislation that I am going to introduce that does differ a little bit from your approach, and I would hope that this subcommittee would consider it. Basically, what I would do, instead of a 2-year pilot program, it would implement it as soon as possible system-wide.

My formula is a bit different than yours. A third of it would go to where the hospital services are rendered; a third would go to a special pay account to improve the ability of the VA to attract and retain health care professionals, particularly the nursing professionals; and the final third would go to the Department of the Treasury for deficit reduction if the Congress had not voted a supplemental appropriation during the past year. If a supplemental had been approved, then a third would go to an account available to the chief medical director for equipment training and other vital health care-related functions.

Based on the estimates that we have gotten in my office, I have heard that to improve the billing efforts could bring in a minimum of $500 million to more than $2 billion each year into the VA health care system. It is being done effectively every day in the private sector, and I think that Dr. Rowland could testify to that also. So it is not something that we are going to be doing new, it has already been done in the private sector, and I think we could implement that into the VA system.

One thing I would like to stress, though, that this should not be viewed as a way to cut our appropriations. We have a need for the money, and that is why my formula would say that a third of it would go into the hospital that rendered the care.

Two final points: You mentioned in your introduction that I may talk about collection. We do a job in the VA centers. Some do a very good job. Martinsburg, W. Va., is the No. 1 collection hospital in the country, and, of course, that is one of the reasons I am here, because we do such a good job, but we don't get rewarded for that; that money comes back to Washington; and that is why I would like to see it go to the hospital that does render the care.

To my colleague, Mr. Bilirakis, I would say that some of it is competition as far as nurses go. In the Martinsburg area, because we are so close to some of the other urban areas, it is just competition. The nurses get paid more for less time. Also, the nurses in the VA system—and what I am finding in our State—are asked to do a lot more than just be nurses. Because of some of the cutbacks, they are now being clerical workers. So I think there are a lot of different things that we need to look at, especially with nurses, not just the pay. I think there are a lot of the working conditions we have to be very much aware of also.

With that, Mr. Chairman, I would answer any questions of any of my colleagues.

I would ask that you do look at my legislation and look at my approach, and hopefully when you do consider the chairman's bill that you would look at my approach also. I look forward to working with the subcommittee. I work in the committee; I will work with the subcommittee.

I do have a prepared statement, Mr. Chairman, and I would ask unanimous consent that that be put into the record.

[The prepared statement of Congressman Staggers appears at p. 81.]

Mr. MONTGOMERY. Thank you very much.

No question about that. It has been a pleasure having you on the committee and also being the chairman of one of the subcommittees.

Let me mention, just for my own clarification, in H.R. 901, I do have third-party reimbursement, and let me try to explain to my committee members, especially new ones, the law the committee passed in the 99th Congress provides that where a veteran is non-service-connected and comes into a veterans' hospital and he has a health insurance policy, he may claim in the same way that other persons from private hospitals, from charity hospitals, to public hospitals, collect on this insurance from the insurance companies. We hadn't done that for 50 years in our VA system, so we now have that the different directors of the hospitals where a person is non-service-connected and has a health care insurance policy, that they go to the insurance company and collect these funds.

Well, they hadn't done a very good job on it. The money does that comes in goes in the General Fund of the Treasury, and even if it is collected it doesn't come back to the VA hospitals. Basically, my bill, H.R. 901, says it will come back into the VA hospital system, and especially to that hospital that does a good job of collecting funds.

You would suggest—you don't have a bill on it—that a third would go to the hospital, a third would go to the special pay account, and that a third would go into the Treasury, to do what?

Mr. STAGGERS. You are right. I think on page 14 of your bill you have 25 percent goes to the Treasury as miscellaneous receipts. 25 percent would go to the hospital, and 50 percent would go to the chief medical director. Mine differs in the fact that a third of it would go, I guess, like your part 2; a third of it would go to the hospital that provides the services, instead of 25 percent; a third of it would go to the special pay account, which differs a little bit from your bill; and then a third of it would go to the Treasury for deficit reduction if Congress had not voted a supplemental appropriation during the past year. If a supplemental had been approved, then the final third would go to an account available to the chief medical director, which is similar to your part 3.

So mine is not totally different than yours; it is very similar to your approach. I guess one of the things that differs most drastically is, I don't think that we can afford to wait 2 years. I think that methods are there. We could improve collections immediately, and we would not need to wait the 2 years. The money that is collected would help by going to the VA centers. I like your idea; I don't disagree with you.

Mr. MONTGOMERY. Well, I generally like what you are doing here, too.

Any comments or questions from Members?

John Paul.

Mr. HAMMERSCHMIDT. Mr. Chairman, I don't have any questions, but I want to thank Harley for bringing us his testimony and his valuable thoughts to this subcommittee.

Thank you, Harley.

Mr. STAGGERS. I appreciate that.

Mr. MONTGOMERY. We could pick up a sizable amount of money if we did a better job on collecting from these insurance companies. The veteran buys his policy, and it only seems fair that if the insurance companies pay private hospitals or pay for calls to doctors, we certainly are entitled to be considered on these claims.

Mr. STAGGERS. Mr. Chairman, on these points, I would reiterate that if we do it system-wide the estimates are between $500 million to $2 billion a year that could come back into the system, and I think that is a large pot of money.

Mr. MONTGOMERY. Would you say that again, Harley.

Mr. STAGGERS. The estimates that we have, if we improve the billing system, could bring in a minimum of $500 million to more than $2 billion each year into the VA health care system. When you say that this will bring money in, whether it is your plan, or whether it is my plan, or whether we do it on a 2-year pilot program, you are right, this is going to bring money in, and I think it is extremely important that we do one or the other, either do your pilot program or go the whole way and do mine system-wide.

Mr. BILIRAKIS. Mr. Chairman, I would like to hitchhike upon that, sir, by saying, in my opinion, based on the experience we are now seeing with this catastrophic health plan and the fact that premiums for Medigap policies, AARP, et cetera, have gone up rather than down in spite of the fact that the exposure has dropped, we are not talking about increasing the premiums on the veterans. They are probably paying them anyhow, and the insurance companies have not given the proper credits for it.

Mr. MONTGOMERY. I am glad the gentleman from Florida is not going to offer an amendment like he did yesterday, that I read in the paper, to repeal certain sections of the catastrophic——

Mr. BILIRAKIS. You didn't like that amendment?

Mr. MONTGOMERY. No, I didn't say I didn't like it, I just said not to offer it here.

Mr. BILIRAKIS. No, I would not.

Mr. MONTGOMERY. Thank you.

Any other questions?

Harley, thank you very much.

Mr. STAGGERS. Thank you, Mr. Chairman.

Mr. MONTGOMERY. Thank you.

Dr. John Gronvall, the chief medical director of the Veterans Health Services and Research Administration, Department of Veterans Affairs.

I believe, Dr. Gronvall, you have a team with you.

Without objection, the gentleman from West Virginia's full statement will be put in the record.

Dr. Gronvall, as your group is coming up, let me make two statements that I hope the Members will listen to and also that our witnesses will listen to.

Like all other Department of Veterans Affairs testimony, Dr. Gronvall, it didn't get here until late yesterday afternoon. This makes it impossible for us to forward the testimony in advance to our members so that they may look at questions based on the testimony they might want to ask. I would hope that in the future the Department, as well as other witnesses—you are not the only one, Dr. Gronvall—could deliver its testimony 48 hours in advance of the hearing, as required by the committee rules. Mr. Stump, the ranking minority member, feels very strongly about this. This is not our rule basically, this is really the rules of the House, that we have to get this testimony in.

Now the other statement I would like to make. Unlike some other committees, the Veterans' Affairs Committee and its subcommittees have not routinely sworn in witnesses at its hearings. Instead, the committee has relied on personal and professional opinions of the witnesses—and I am talking about those who work for the VA—to obtain the expert responses needed in oversight and legislative activities. In the past, there has been some fear that something might be done against VA employees who come and testify before this committee.

I have talked to Secretary Derwinski, and I am pleased to say that he has publicly stated his intent is not to restrain any kind of exchange between VA employees and not to take any action against any type of VA employee who comes before this committee. We don't like to swear in people, but we certainly want to get to the bottom of the issues, and Secretary Derwinski says that is fine with him, and he wants his Department of Veterans Affairs employees to tell it like it is.

Dr. Gronvall.

STATEMENT OF JOHN GRONVALL, CHIEF MEDICAL DIRECTOR, VETERANS' HEALTH SERVICES AND RESEARCH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY ARTHUR LEWIS, DEPUTY CHIEF MEDICAL DIRECTOR; JOHN LEE, DIRECTOR, MID-ATLANTIC REGION, PAUL ERRERA, DIRECTOR, MENTAL HEALTH AND BEHAVIORAL SCIENCES SERVICE; FREDERICK DOWNS, DIRECTOR, PROSTHETIC AND SENSORY AIDS SERVICE; GREGORY J. HAAG, DIRECTOR, HEALTH CARE STAFF, DEVELOPMENT AND RETENTION; RALPH IBSON, DEPUTY ASSISTANT GENERAL COUNSEL; AND VERNICE FERGUSON, CHIEF, NURSING SERVICE

Dr. GRONVALL. Thank you very much, Mr. Chairman.

It is a pleasure to be here, and I apologize to you for the lateness of our statement. There were reasons why it was late, but those would only appear as excuses, and so I prefer to apologize and promise to you that we will redouble our efforts to not let that happen again.

I also appreciate your comments on our testimony and can confirm that the Secretary has pointed out directly to us that he expects us to be forthright, truthful, and give full and direct and honest testimony in every hearing where any of us appear. So I appreciate that comment very much.

We do have a very long and detailed statement.

Mr. MONTGOMERY. Without objection, it is in the record now, and if you will move on briefly, the Members would like to ask some questions.

Dr. GRONVALL. Thank you. The statement is over 30 pages, and so I will give a very brief summary. Just let me list the people that are here at the witness table with me. To my right, Dr. Arthur Lewis, who is Deputy Chief Medical Director; and I appreciate, Mr. Chairman, your understanding that I am to be at another hearing, but Dr. Lewis, my deputy, will continue here as the VA lead witness when I have to leave. Next to him, Dr. Paul Errera, who heads our mental health programs; and, on the far right, Mr. Gregory Haag, who heads a new office that is working full-time on recruitment and retention issues. To my left, Mr. Fred Downs, who heads our prosthetics program; next to him, Mr. John Lee, who is our Regional Director for the Mid-Atlantic Region; and, at the far end of the table, Mr. Ralph Ibson from the General Counsel's Office.

We very much appreciate the legislation that has been introduced to address the nursing recruitment and retention issues. There are a number of provisions in the bill, H.R. 901, and a number of provisions in Mr. Kennedy's bill, H.R. 1199, that would assist significantly in our ability to recruit and retain nurses.

The proposed legislation, H.R. 1199, would accomplish a major restructuring of the pay system for nurses. In our view, it would solve a number of very long standing problems that we have had. We, within the VA, have had a very active nurse pay task force that has been working on all of these issues, and we find that the preliminary positions developed within the VA are consistent with many of the provisions in the Kennedy bill.

We believe that enactment of the legislation should await completion of some additional details from our own task force effort, and we would seek to work further with the committee on some of those details as they become completed and, we believe, could lead to improvement in the legislative proposal.

We also are pleased to see the legislative effort to enhance our compensated work therapy program to include a housing component. We believe that this would be a major step to assist us in addressing the problems of homeless, chronically mentally ill veterans. We are developing additional detailed proposals and, again, would request that the committee defer final action until a detailed legislative proposal can be forwarded from the VA.

There are many other proposals on today's agenda which we support, and our detailed statement lists those one by one.

Let me comment briefly on the proposals regarding collection of third-party reimbursement fees. As our statement points out, we do not support your proposal directly as it is drafted, but, again, we are very interested in working to develop acceptable legislation to conduct either a pilot program or an expanded program of third-party reimbursement collections. We believe that it will be valuable to utilize some of the funds that are collected to pay at least the costs of collection and provide a stronger incentive for collections.

We are also interested in expanding our VA/DOD sharing interface and for looking for a way to incorporate the care of some DOD dependents in our VA medical centers. Once again, there are complicated details in many of those proposals that need further development.

For reasons that are detailed in our statement, we do not support the specific provisions that are in the current legislative agenda for mandatory Saturday premium pay, for the new requirements related to the CHAMPVA program, for several of the specific legislative proposals regarding our canteen service, or the modifications to our community nursing home program.

Mr. Chairman, with that summary, thank you again for our opportunity to appear today and to discuss these very important legislative proposals. Thank you.

[The prepared statement of Dr. Gronvall appears at p. 86.]

Mr. MONTGOMERY. I would only ask one question. About a third of the members on this committee serve on the Armed Services Committee also. I notice that you are opposing the VA/DOD sharing agreement that I have in here where dependents would—if a bed is available, and the way it is drawn up, it is up to the director or you, the administrator, to let dependents come into the VA facilities where beds are available, and the military would pay us for those dependents from the military coming into the VA hospital system. I would wonder why you would oppose that, Dr. Gronvall.

Dr. GRONVALL. Mr. Chairman, I myself and the the Department of Veterans' Health Services and Research Administration officials have been working in collaboration with our colleagues at the Defense Department. I have discussed this with each of the Surgeons General and with the Assistant Secretary for Health Affairs, Dr. Mayer, and I think we believe that——

Mr. MONTGOMERY. Dr. Mayer has gone. Let's not start quoting him now.

Dr. GRONVALL. All I am referring to is past work that we have done, and I can tell you that we and the military medical people believe that expanding our sharing agreements and seeking ways to care for military dependents in VA hospitals where we have a space available is appropriate.

Enactment of a legislative initiative of a sweeping nature to do that raises a number of policy questions in the administration that have not yet been worked out, and it is for that reason that we say we believe the proposal needs further development.

Mr. MONTGOMERY. You are just not putting a "no" stamp on it at this time.

Dr. GRONVALL. Correct.

Mr. MONTGOMERY. Thank you.

Mr. Hammerschmidt.

Mr. HAMMERSCHMIDT. Thank you, Dr. Gronvall, for your testimony.

Doctor, you state that your newly established nurse pay task force is developing a long-range pay proposal, or a long-range proposal, for revision of the title 38 nurse pay system. Can you tell us when that proposal will be completed?

Dr. **Gronvall**. Mr. Haag is working full time as the head of the office that is developing this.

Mr. Haag, when do you believe we will have a full proposal prepared?

Mr. **Haag**. We have submitted that to some of the experts in Central Office, and we are expecting them to respond within the next few weeks. Depending upon their replies and us being able to put it together, I would imagine we would have it ready by the first of May.

Mr. **Hammerschmidt**. So you have a tentative draft proposal. It is just circulating the top desks at the VA. Is that correct?

Dr. **Gronvall**. Yes. I think most of the proposals that we want to put forward are well worked out. There are a few finishing touches, and so within about the next month we would have a detailed proposal.

Mr. **Hammerschmidt**. Does that go to OMB for their comments?

Dr. **Gronvall**. Yes. Specifically, since the proposal to restructure and increase pay will have significant financial implications, that would require the normal executive branch review and submission of a legislative proposal with funding estimates attached.

Mr. **Hammerschmidt**. The Secretary of Health and Human Resources' Commission on Nursing reported that entry level salaries in the VA are too low and should be elevated. Dr. Gronvall, do you concur with this statement, and, if so, how much should entry level salaries be raised to be competitive with the private sector?

Dr. **Gronvall**. Yes, I concur with the statement, and that is part of our proposal. As to a specific dollar figure, Mr. Haag, could you elaborate?

Mr. **Haag**. The task force recommended a market-sensitive or a locally based proposal in which each facility or group of facilities as may be in a particular market area would survey the area and initiate a proposal that would be comparable at the first three levels and extrapolated from those levels, similar to the schedules we have now for longevity rates as well as for increments between the promotional grades.

Mr. **Hammerschmidt**. I'm sorry, I might not have understood. Did you name a percentage or a dollar figure in your response?

Mr. **Haag**. No. It would be based on each locale or market that we are dealing with, and we would look towards that market and establish our rates according to what was being paid by the hospitals in the market area.

Mr. **Hammerschmidt**. In other words, what it takes to get nurses into the VA system out of that particular market area.

Mr. **Haag**. That's right.

Mr. **Hammerschmidt**. Thank you very much.

Thank you, Mr. Chairman.

Mr. **Montgomery**. Thank you.

The Chair will go by the way that persons came in after the Chair called the meeting to come to order.

Tim Johnson of South Dakota.

Bob Stump.

Mr. **Stump**. Thank you, Mr. Chairman. I just have one question.

Doctor, what is the average percentage of outside nurses or contract nurses that you have to bring in? Do you have any figures on that?

Dr. GRONVALL. I do not have a precise number of the contract nurses, but we do have data which we track year by year. I think it is best for us to submit that in detail. Our experience is that each year and, in fact, each month we are having to employ additional nurses on contract because our own pay schedules are not competitive in a number of areas of the country. But we will supply a detailed answer to that question.

(Subsequently, the Department of Veterans Affairs furnished the following information:)

The utilization of contract nursing personnel by VHS&RA has increased substantially during recent years. FTEE utilized and cost is as follows:

	FY 1986 (Actual)	FY 1987 (Actual)	FY 1988 (Projected)
Registered nurses:			
FTEE	17.03	69.94	178.45
Cost	$639,499	$2,716,321	$8,241,949
Licensed practical nurses/licensed vocational nurses:			
FTEE	6.22	6.75	8.12
Cost	$169,547	$246,586	$336,539
Nursing Assistants:			
FTEE	0	2.3	.70
Cost	0	$52,690	$22,717
Total-all nursing personnel:			
FTEE	23.25	78.99	187.27
Cost	$809,046	$3,015,597	$8,601,205

Mr. STUMP. Thank you, sir.

Thank you, Mr. Chairman.

Mr. MONTGOMERY. Dan Burton.

Mr. BURTON. Thank you, Mr. Chairman. I just have one question. In my opening remarks, I mentioned that there have been two wards closed down at the Roudebush Hospital in Indianapolis, and I don't know whether you have the statistical information or not, but as a result of the pay scales and the nurse shortages, how many wards across the country, how many beds, have been removed from our facilities?

Dr. GRONVALL. I do have approximate figures at my fingertips. About 25 percent of our medical centers have specifically closed beds as a result of a shortage of funds or a shortage of nurse staffing, and at the present time about 3,000 beds are closed across our system as a result of those shortages.

Mr. BURTON. Let me just follow up with one other question. Do you know how many, if any, veterans should be entitled to go into these facilities, and how many have been turned away as a result of these shortages taking place?

Dr. GRONVALL. Yes. I can compare our current year experience, the first 5 months of this fiscal year, 1989—namely, the months of

October, November, December, January, and February—with the 5 months of fiscal year 1988. During this current year, we have had an increased number of veterans seeking care in the VA during that 5-months period of about 150,000. That is about a 10-percent increase above a year ago.

We have, because of the constraints on our system and personnel shortages and beds closed, treated about 20,000 fewer veterans in our hospitals during that time—that is on a base of 500,000. Our out-patient clinic visits also during that 5-months period has increased slightly.

So we have seen demand increase, and our ability to deliver care has been constrained, so we are providing less care in spite of the increased demand.

Mr. BURTON. I would just like to make one comment to our chairman. At the Roudebush Hospital in Indianapolis, we have been in a modernization program, and the VA has appropriated, I think, $8.4 million to renovate that facility; it seems to me ludicrous to improve the facility and then not be able to provide beds for the veterans who need them.

So I think it is really imperative that we move this legislation as quickly as possible, Mr. Chairman.

Mr. MONTGOMERY. Thank you.

We certainly need that supplemental any way that the subcommittee members can help us on that. We have over $300 million tied up in supplemental, and the Appropriation Committee is being weighted down by other amendments being added to it. We might have to break it out and bring it out separately. So I want the Members to know that. We really, in effect, need a dire supplemental, they call it, which would include veterans hospital funding and several other items, and bring it out as quickly as possible. As I said in my statement, I certainly hope before the end of this month that we could get some money and do some things that you mentioned.

I am going by the list.

Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

I, in my limited time, would like to explore the area of attrition, as I mentioned in my opening remarks, sir, and hopefully our committee can follow up on that and stay with it, because that is where much of the problem lies, obviously, I think.

Dr. Gronvall, again, welcome, sir. You are always welcome to come before this committee, and we appreciate all of your work.

Regarding the problem of drug abuse and alcholism—and I say it in such a way that I am assuming that there is a problem in the VA medical system regarding that area—do you have any figures on the number of nurses that the VA has lost due to drug abuse and/or alcoholism?

Dr. GRONVALL. I surely don't have those figures. I am aware of individual case reports, because those are very painful when members of our staff have to be dropped as a result of those problems. I would have to ask our staff to see if we have accumulated figures and get back to you with an answer to that if we have the information.

(Subsequently, the Department of Veterans Affairs furnished the following information:)

The Department of Veterans Affairs (VA) does not keep statistical data on the number of employees who have left the VA due to alcoholism or drug related problems. Our official records only list the employee's reason for leaving, without any indication as to whether substance abuse may have been an underlying factor.

VA facilities do offer comprehensive employee assistance programs which are designed to provide rehabilitative assistance to employees with personal problems, such as substance abuse, which are affecting their performance. Such assistance is offered on a confidential basis. Employee participation is strictly voluntary. While statistical data is kept indicating the specific problem which caused the employee to seek treatment, the data is no maintained by occupational category.

Mr. BILIRAKIS. All right. Well, let me ask you a question then, apparently you are acknowledging that there is a problem. I am not saying that it is a major problem; your figures will better determine that. So what procedures does the Department follow if there is a finding of drug or alcohol abuse?

Dr. GRONVALL. We have, I think, a well developed program of dealing with individual members of our staff who are discovered to have a problem either with alcohol or substance abuse. It involves counseling to assist the staff member in rehabilitation and getting out of the habit. When a person's work is being impaired, we ensure that that person is not carrying responsibility for patient care, so we take those kinds of steps while we are working on trying to adopt rehabilitation. If it becomes apparent that the person is not going to be rehabilitated and is being impaired, then we take steps to drop them from our employment rolls.

We, along with the entire Federal Government, of course, have been part of the effort to establish drug testing as a part of a surveillance mechanism. We do have a proposal nearing completion to implement drug testing for employment applicants in the VA.

Mr. BILIRAKIS. Employment applicants but not the current employees?

Dr. GRONVALL. Correct. That question is currently the subject of intense legal action, and I don't know what the outcome of that is going to be.

Mr. BILIRAKIS. Well, would we acknowledge, sir, that there is somewhat of a problem in the VA medical system?

Dr. GRONVALL. Oh, yes, I would acknowledge that there is a problem. Based on the number of cases that I have seen reported, it is a minuscule one in terms of the size of our total work force of nurses, doctors, and other professional staff, but any individual who has a drug or alcohol abuse problem and becomes impaired is a significant problem, so I'm not minimizing it when I say that it is minuscule in percentage terms.

Mr. BILIRAKIS. All right. Let's go into the subject of burn-out then, and that is something, God knows, we experience up here, I speak for myself.

Well, does the Department, sir, have support systems for nurses who are exhibiting burn-out? In other words, it seems to me that those who exhibit such signs as a consistent pattern of lost days should have access to a support group. In the long run, this, I think, would benefit both the individual nurse and the VA medical facility if we can alleviate burn-out and drug and alcohol abuse. I am sort of putting all those into the same category as far as support groups go.

Dr. **Gronvall.** Yes, I surely agree, and a key part of the responsibility of our managers in the system in our hospitals, the chief nurse in this case and the head nurse on each ward and unit, is to ensure that the staff remain invigorated and are protected from burn-out and are dealt with when those symptoms occur.

We have tried to expand our training programs and our ability to help retool people, keep them up to date with current practice. It has been made difficult by the problems that have been described here of our salary schedules not being as competitive, and the expanding workload that we have been dealing with has meant that our nursing staff, like our physician and other staff, have had to deal with an expanding patient load.

So it has become an increasing problem for us, and one of the things we have particularly wanted to do through our new recruitment and retention office, headed by Mr. Haag, is to redouble our efforts nationally to ensure that we look for all of those ways to keep our staff well informed, up to date, avoid burn-out, assist them when they do get tired out in getting retooled to stay on in a successful practice career.

Mr. **Bilirakis.** My time is up. Thank you, Doctor. Thank you, Mr. Chairman.

Mr. **Montgomery.** Thank you.

Dr. Rowland.

Dr. **Rowland of Georgia.** Thank you, Mr. Chairman.

Dr. Lewis, let me thank you for the information that you provided to me on a person who wanted to retire in my district, an employee; that was real good; I appreciate your getting back to me with that.

Dr. **Lewis.** Thank you.

Dr. **Rowland of Georgia.** Dr. Gronvall, let me ask you this. We have had some budget hearings and committee surveys that have revealed that some big hospitals are using some of the prosthetic accounts to meet operating expenses, and of course what this has done is to delay or actually deny prosthetic services in some cases. Can you give me your personal opinion about how we ought to deal with that?

Dr. **Gronvall.** That is correct. The directors of our medical centers and our chiefs of staff get put in a very difficult position where they have urgent crisis and critical kind of medical care needs from veterans coming in with heart attacks, cancer that needs to be treated. The prosthetic devices or replacement of prosthetic devices can in many instances be scheduled, and what happens when the budget crunch hits an individual medical center, they have been forced to borrow funds that are assigned to prosthetics, delay the schedule of replacing prosthetic devices, in order to meet those urgent and acute care needs.

We have had a task force working this past year. It has made a number of recommendations. We are about to adopt some recommendations. The central thrust of that will be to tighten our management and control and allocation of the prosthetic funds to assure that those funds, as provided in the appropriation, are available for the prosthetic devices they are intended to purchase. But it has been a difficult problem for us.

Dr. Rowland of Georgia. Do you need to leave?

Dr. Gronvall. Yes. I have been asked to be at another hearing, and I understand the chairman has agreed that I may leave, and Dr. Lewis will continue as the lead witness.

Dr. Rowland of Georgia. Well, I will ask the question. I have a follow-up question, so I will ask whoever you designate.

Dr. Lewis, I have got a hard question. I am sorry to have to ask you this since Dr. Gronvall is leaving.

Dr. Lewis. Shall I ask him to come back?

Dr. Rowland of Georgia. That's up to you.

In looking at the budget crunch—and those were Dr. Gronvall's words—that we are now having, and we have already alluded to the fact that we have had a straight line over the past several years, not taking into account the increase in the number of veterans that we have been treating, and looking at the third-party reimbursement, Dr. Gronvall, in his statement, does not approve of that, saying that the money ought to go in the General Fund.

We don't do very well when we try to get money out of the General Fund, and the problem we have with the prosthetics is one example, many of which there are in Veterans' Administration hospitals, of not being able to meet their expenses, and that these funds go into the General Fund from collection from insurance companies, and they would be charged against accounts that you already have in place.

But this legislation that has been proposed would not allow that to happen. So I find it odd that Dr. Gronvall's Department of Medicine and Surgery would not be wanting to get additional funds to help offset some of the problems that we already have in deficient funds and would want this money to go in the General Fund.

As I understand it, there is a great deal of money that could be collected, and what incentive does an individual VA hospital have in trying to collect this money if they don't even have the money to meet the expenses of doing that?

Dr. Lewis. I think that there is a question of shading in this, Congressman Rowland. I don't think that it is an issue that we do not agree that there is a problem. I think our concern is how best to address the problem.

We recognize that currently there is no incentive, real incentive, to the medical center director to implement this, other than the fact that he has been told he is expected to implement third-party collection.

We have concerns that unless the plan is very carefully crafted we will not achieve any improvement in terms of the amounts that we will be able to recover and put to productive uses other than offsetting any budgetary requirements. I think what we would like to do is to work with the committee to see if we can't devise a process wherein we could accomplish what you are interested in and what we would like to accomplish, for example, if we were to get involved with a billing process, that the money that would be recovered would be able to be used to pay those costs for the billing.

So I don't think that there is outright opposition to the chairman's proposal, just a concern that the desired result will not occur.

Dr. **Rowland of Georgia**. Well, his statement indicates that he is opposed or would be opposed to that.

My time is up. I want to come back to this.

Mr. **Montgomery**. Mr. Kennedy.

Mr. **Kennedy**. Thank you, Mr. Chairman.

Dr. Lewis and other representatives of the VA, it is good to see you up here this morning talking about the fact that there is, indeed, a shortage of funding for Veterans' Administration nurses.

As I recall, last year we had to have a hearing on this issue in order to get the VA to even recognize that we had a significant problem. So I think it is a real step forward that we now are dealing with the problem and admitting that there is one.

However, I was somewhat dismayed by Dr. Gronvall's testimony suggesting that another study has to be done now to determine the kind of relief that nurses ought to, in fact, get. It just would appear to me, and I think to everybody on this committee who have been hearing directly from nurses if not directly from our veterans that are part of our constituencies—those of us that have VA facilities hear directly from them all the time—about the kinds of terrible problems they have with paying for nursing positions and the terrible amount of cutbacks that they have had to make in hospital services in general as a direct result of the nursing shortage.

So my question to you would be, is there a specific problem that you have with either the chairman's bill or with H.R. 1199 that would suggest that for some reason we have to wait for additional study, or, in fact, do you support the bills and therefore we can just move forward on the legislation?

Dr. **Lewis**. I think, again, as Dr. Gronvall indicated, the approach that we would like to take would be to allow our task force to report back to us and make some recommendations and allow us to handle this our way through the legislative process.

I don't think that there is any overall disagreement with your bill. I think that in many respects it is consistent with our own ideas. I think we have some concerns here about the costs of the bill, the funding of both your bill and the chairman's bill, and the impact that this will have on our budget, lest the money have to come from current medical funds.

Mr. **Kennedy**. But, Dr. Lewis, it does seem to me that that is exactly the same dynamic that we face on many issues with regard to VA funding. It just seems to me once again provoking this kind of bizarre situation where you have the Congress—you talked about the reason, the essential reason, why you don't want to move forward is because of the legislative process, but you have got legislators up here, including the chairman of the committee as well as other Congressmen, most of them sitting around this table right at the moment, who have in fact supported additional funding for VA nurses. So we have already established what the problem is, we have come up with a legislative solution, and now what we are doing is waiting for the VA to catch up to where the committee is and where the problems are. I mean the nurses' groups who are up here will tell you all day long about the problems that exist.

So it does seem to be kind of putting the cart before the horse in the sense of recognizing that you have got the legislators already on your side, so let's move forward and get the legislation done.

If you have got a specific problem with the legislation, I'd like to hear about it. If you support it, then just say it. Let us do the battle in terms of where the budget comes out. I mean you know how well Federal agencies have done in standing up to OMB lately; you haven't even had to do that yet. This legislation has bipartisan support; Mr. Rowland from Connecticut is a sponsor of it; I'm a sponsor of it; the chairman is a sponsor of it; we ought to move forward on it.

Dr. LEWIS. I think the statement itself says, and I would repeat this, that in many respects it is consistent with essentially what we want. On the other hand, as I say, we do have, I think, the concerns that our nursing shortage, while it is acknowledged, is not a universal problem across the country. There are some areas where it is very severe; there are other areas where it is not a problem at all.

Mr. KENNEDY. The fact is, Doctor, that last year's legislation provided an across-the-board. The legislation that is filed this year is, in fact, targeted toward specific areas to deal with the very problem you are talking about. So I just wonder, do you endorse this legislation?

Dr. LEWIS. Well, I have a wife who is a nurse, and I am sure if you'd ask her she would say yes.

Mr. KENNEDY. Thank you very much, Doctor.

Mr. Haag, do you support this legislation?

Mr. HAAG. It certainly addresses the concerns that were expressed by our task force.

Mr. KENNEDY. Great. Do you think we could get a "yes" out of them, Sonny, or what?

Mr. MONTGOMERY. You've done better than I've done. I've been doing this for about 18 years, and you've had better answers than I've had.

Mr. KENNEDY. Anyway, thank you.

Mr. MONTGOMERY. Thank you.

Why don't we have questions from one more Member; that would be Claude Harris of Alabama; and then we will recess; we do have a vote. After this panel has finished, we have two other panels, and I would like to ask Dr. Rowland when we come back to take the chair.

Claude Harris.

Mr. HARRIS. Mr. Chairman, I don't have any questions since I missed the testimony. I'll just have to study it and read it later.

Mr. MONTGOMERY. Thank you. Thank you for coming.

Mr. Ridge.

Mr. RIDGE. Mr. Chairman, I would like to follow up on Mr. Kennedy's point. That is why I wanted to stay with the same discussion. And I will remind my colleague from Massachusetts that for the last 4 years I have been having an ongoing discussion with Dr. Gronvall about the nursing shortage, and there are some mixed emotions here.

Number one, for a number of years the VA would not admit there was a nursing shortage; they were examining that whole question. So we have come a little way now that they have almost admitted there is nursing shortage, although we will agree it is in particular areas.

I am very distressed that, as Mr. Kennedy indicated, we have got a great deal of support within the committee, we now have Dr. Lewis on board, and I am concerned that if we take the so-called task force report and send it to the black hole over at OMB it will never be seen again.

So my key question is this: Perhaps to Mr. Haag. Can you enlighten us with the new, creative, innovative ideas that the task force is bringing forward that we should all be waiting to hear and waiting to debate and waiting to pass in this legislation, hopefully before the rest of us are on Social Security?

Mr. HAAG. To give you an idea of the makeup of the task force, this was all field people. We felt there would be considerable benefit in having that perspective. As I indicated, the concerns that were addressed, and they are being addressed in H.R. 1199, are that there must be competitive entry-level salaries; the problems of special salary rates have to be addressed; pay compression at middle and upper grades; pay recognition for head nurses; performance recognition for nurse managers; and preservation of rank in a professionally oriented system. As indicated, here again, H.R. 1199 does address them but in different forms.

The task force does recommend a percentage increase for head nurses as opposed to steps. There doesn't appear to be a considerable difference there, and the reason for that primarily is that the head nurse is not always a permanent position, and it is easier to recognize that position by having it paid in a way that the funds can then be withdrawn without adversely affecting some of their other benefits.

There is also the problem, I believe, that is not addressed, and that is the funding at the local levels. This appears in some of our considerations that the hospital directors are already stressed out in terms of where to get the money from. For them to make the decision at that level and wait through the budget cycle, which could be as much as 2 years, for the funding to come along to support their decision would be a rather difficult problem for them at this time.

Mr. RIDGE. Mr. Haag, I would merely add that I am pleased to see that your position has been created for recruitment and retention. I would merely caution all of us involved in this issue that we are losing good nurses, we are losing good, fine people, and we are not attracting enough nurses. There are troubles in the private sector with attracting nurses, and I can assure you that the VA is not any more attractive than the private sector at this stage of the game.

So if you are serious about your position on recruitment and retention, it would be my hope that we would move in lock step. We have defined the problem, we have agreed that there is a problem, there are a few "t's" to be crossed and a few"i's" to be dotted, but in essence I think we have got the basic solution. If we start working with OMB, I can bet, I will go out on a limb and say that there is no way in the world OMB is going to endorse any of these recommendations. We can solve the problem, and I hope we will.

Mr. **Montgomery**. We have about a minute left. Bruce Morrison.

Mr. **Morrison**. I will be very brief. I have two very brief questions, and they could sort of get a "yes" or "no" kind of answer.

Dr. Lewis, with respect to the issue of premium pay, the testimony says that mandatory premium pay for Saturdays for nursing assistants and LPN's is not necessary because there is adequate discretionary authority. It is my understanding that there is not discretionary authority to have Saturday premium pay for nursing assistants, because they are title 5 employees. Isn't that correct?

Dr. **Lewis**. Yes.

Mr. **Morrison**. Well, it is my understanding, or at least what I am told in Connecticut in our VA medical center is that nursing assistants cannot under any circumstances be paid Saturday premium pay; it is not authorized. Is that correct? In other words, there is no discretion. We have asked for it. The director of the center has suggested that it ought to be paid, at least in certain circumstances, but that the law does not permit it. Is that correct?

Dr. **Lewis**. Yes.

Mr. **Morrison**. Well, I would like your clarification. If I am correct, the testimony is quite incomplete, because it suggests that we don't need to deal with this, but it kind of glosses over these nursing assistants completely, and I would hope that the Department might consider revising its position, because the testimony suggests it ought to be allowed on a discretionary basis, but I don't think it is, and I would hope you would reconsider your position if what I am saying is correct.

Dr. **Lewis**. I think what we are saying is that we would welcome receiving the discretion to do this on a case-by-case basis.

Mr. **Morrison**. Well, if that is correct, I hope you will issue a regulation immediately so we can solve our problem in West Haven and elsewhere around the country, because we have been hassling about this for a couple of years now.

Mr. **Montgomery**. If that is an important question, we will just have to come back. We have got about 2 minutes to get over there.

Mr. **Morrison**. Okay. I don't want to hold the panel if it is only for me, but I do have another question.

Mr. **Montgomery**. I believe L.F. Payne is here. Do you have some questions? We will just have to come back.

Mr. **Payne**. I have questions, but I will put them in the record, if I could.

Mr. **Morrison**. Mr. Chairman, I will come right back, if I could just have them for one more question.

Mr. **Montgomery**. Okay. The subcommittee now stands in recess. Dr. Lewis, if you will stay at the witness table, that will help.

[Recess.]

Dr. **Rowland of Georgia** [presiding]. The subcommittee will come to order, please.

The gentleman from Virginia, Mr. Payne, is recognized.

Mr. **Payne**. Dr. Lewis, I am one of the original cosponsors of H.R. 901, and also a supporter of what Mr. Kennedy and others here are attempting to do in terms of making the VA more competitive and improving our health care to veterans.

There is in H.R. 901 a provision which I consider to be very important, and it is one that Dr. Rowland spoke about earlier, and I would like to ask you about that one more time, and hopefully this won't be redundant.

This provision has to do with the collection of non-service-connected veterans, the moneys that are due to the VA as a result of their stay in the veterans' hospitals from insurance companies. You may have heard our colleague, Mr. Staggers, earlier who estimated that this could result in some $500 million to perhaps as much as $2 billion annually if we were successful in collecting the moneys that are due. His suggestion to the committee was that we proceed more rapidly than H.R. 901 would have us proceed. Dr. Gronvall suggested that we needed to look at this further and perhaps proceed more slowly than H.R. 901 would suggest.

Could you clarify in terms of the timing, is this something that you see us progressing with after we have these discussions that you alluded to earlier, that we could proceed very quickly on this?

Dr. LEWIS. I would think so. I think what Dr. Gronvall was referring to, and I think what I tried to respond to Dr. Rowland about, is the fact that I think we all recognize the need to collect these third-party payments. Our target this year is $136 million. This is the target we have received from the budget people. I think what we are saying is that we would like to work with Congress to develop a plan that perhaps would protect us against this money being charged against us at budget time. Whether this be Mr. Staggers' bill or whether it be the chairman's bill, I think we recognize the need to do something, and we would be more than happy to work on a pilot project to approach this.

Mr. Lee has had some experience with this down in Region II. Perhaps he might want to comment on it.

Mr. LEE. Mr. Payne, I would be very happy to comment. Region II has had some excellent experience with third-party payment, and currently—as a matter of fact, as of March 31—our goal set by the Office of Management and Budget was a little over $9 million for the first 6 months. We have collected $12 million, the difference being $3 million over our current goal.

The studies that have been made date back to 1982. Mr. Staggers' figures of $500 million to $2 billion depend upon what study you look at. There was a study made by the Administrator, Mr. Nimmo, back in 1982 that indicated that collections should be close to $2 billion. There was another study in 1986 made by Administrator Walters. I think I have the figures on Mr. Walters' study. He said the annual third-party moneys alone would be $871 million. If you add the tort feasors, the co-pay, and the sharing agreements collections could run from $1.2 billion to $1.3 billion annually.

The most recent study was done by consultants at Richmond VA Medical Center. If you extrapolate the Richmond figures to my region alone, which is the Mid-Atlantic Region—and this is 14 months old now, Congressman Payne—the billings of $52 million would go up to $135 million, and the collections of $13 million would go up to $100 million. If you extrapolated that to the Nation, the billings would go from $214 million to $552 million with collections of $67 million going up to $552 million on third-party payees alone.

It depends on what you include in the pot. If you just include third-party payees, I think we would be somewhere between $600 million and $800 million if we were fully operational nationwide.

The observation I would really like to make is that this basic bill is a winner for everybody. It is a winner for the Treasury Department, because with the incentive and using the private sector we would be able to collect three or four times as much as we are collecting now, which means that the Treasury Department, in a 10-year period where they would collect $1 billion under our present system, would probably collect $2 billion; and it is a winner for the Department of Veterans Affairs because we, who are doing the work, would get credit for it and earn it; and it is a victory for the OMB because they have been after us for many years to use the private sector to help us with this. The private sector has been able to collect 85 to 90 percent of the collections they are doing where the VA collection rate is only about 30 percent even in my region which last year went 42 percent over its goal.

So I think the real problem, of course, is whether or not the Office of Management and Budget would allow us to keep the money, and I think that is where Dr. Gronvall and Dr. Lewis have a very prudent reason to say we must control that situation either with this committee or in conjunction with the Appropriations Committee. We must be able to get Mr. Darman to agree not to do that. If the Department of Veterans Affairs is allowed to keep a portion of the funds collected then I think that this proposal has great potential for alleviating some of the Veterans' Administration problems.

Mr. PAYNE. Let me just say—and I know my time is up, but, first, thank you for doing such a good job of collecting these moneys in your region, and I think it is rare that we see opportunities like this in terms of ways that we can enhance the resources that we know are so very scarce. I would certainly strongly recommend that the committee would pursue this and pursue it very quickly, as Congressman Staggers suggested earlier.

Thank you, Mr. Chairman.

Dr. ROWLAND OF GEORGIA. It pleases me to hear you say, Mr. Lee, that you support this concept, and I guess one thing that we need to do is try to explore ways to keep OMB from actually taking money from you to make up this.

Mr. LEE. Absolutely. I think we all support it. Dr. Gronvall has indicated to me that he supports it also, but he is being very prudent about that, and there is a reality that OMB might try to take the money from the Department. We must stop that.

Dr. ROWLAND OF GEORGIA. We will be looking at ways to try to prevent that from happening. I can assure you of that.

Mr. LEE. I know you will. Thank you.

Dr. ROWLAND OF GEORGIA. Let me just ask Mr. Downs something. I want to follow up a little bit on the prosthetic question that I had asked Dr. Gronvall earlier.

Every time we talk about the budget and accounts, we talk about how tight it is and how we have got to look at priorities. Let me ask you this. Should prosthetics, in your opinion, receive special treatment? And, if you think so, how would you go about recommending that we do that?

Mr. Downs. Yes, sir, I believe that special treatment should be afforded to prosthetics, and I think with me it always comes down to the basic individual. If I may relate a certain background to this, and then I will go into some points I believe are important. I have thought about this for many years.

Twenty-one years ago I lost this arm in combat in Vietnam. You have to understand, I was terrified, I was depressed, I was uncertain of the future. A VA employee came by my Army bed at Fitzsimons in Denver, Colorado, and I remember distinctly that day, because he told me that the VA would provide me with an arm, they would provide me with education, and they would provide me with health care for the rest of my life.

That was like the sun coming up on the horizon, because I came from a very poor background, and the only thing I could think of were the so-called cripples in our town that had to beg for a living and were not well thought of. The reason that the VA was able to do that was because of legislation that was passed by an earlier generation of veterans and Congressmen resulting from World War II.

Today, I am now 45, and I look at the disabled veterans that we serve and those we don't serve and those we will be serving in the future, and I have to tell you, I am afraid again. I have lived through this cost containment for a number of years, and the thing that I feel personally has happened is, the human factor has been taken out of the business that we are in, in prosthetics and sensory aids.

So we are now at a time in history when legislation should be passed to cover what I consider the important points in taking care of not only today's disabled veterans but the disabled veterans of tomorrow.

Now that means we need an amendment to section 5023, title 38, United States Code, that would include these items: Mandate adequate funding. Last year, we had a report from 165 of our medical centers that in 1987 there was a $6 million shortage and about 5,000 orders were held; in 1988, there was about a $7.5 million shortage and 7,500 orders were held; this year, they anticipate $10.6 million shortage and 8,500 orders will be held.

Let me tell you that when we are talking about held orders, we are not talking about the groceries, we are not talking about refrigerators, we are talking about arms, legs, wheelchairs, eyeballs, colostomy bags, the things that we need to get through our day-to-day existence.

Second, we need to improve and expand our procurement methods. I'll give you a real quick example. On Sunday night I was watching TV, and on the advertisements this firm advertised that in 45 minutes they could fit you with your eyeglasses and you could walk out; you could do it during your lunch period. I have two members of my staff who are combat-injured veterans from Vietnam. They ordered their eyeglasses from the VA last year, and even though they are in the director's office, it took 45 days.

Third, we have to ensure adequate staffing of qualified disabled prosthetic representatives at all medical centers. We are only considered a service at 82 medical centers. The other 90-plus medical centers are serviced by clerks, and I have found out recently that many of those clerks are not even aware there is a VA policy manual regarding prosthetic services, they are not aware of eligibility and entitlement, they are not aware of the technology available, and I could go on.

Fourth, we must mandate adequate training for these individuals. Each year, I start off with very little or zero training dollars to train these individuals in this complex, highly technical atmosphere for providing this technology to these disabled veterans and preparing them for it's use.

The fifth thing I think needs to be done—and I am speaking very personally here and from my professional experience of being the director for 9 years—there needs to be a yearly report to Congress on the status of those above items, and I say this very strongly because I am concerned for the future, and I feel legislation needs to protect the disabled veteran because the disabled as a class in this country and across the world is at the low end of the scale. We are afraid each time we wake up because we wonder what will happen to us that day. It is not overt, it is just part of our existence. I get up in the morning, and what makes it special is, I put this arm on and I'm ready for the day. Prosthetic and sensory aids is not a glamorous business, we are the basics of life. We enable an individual to regain his mobility, his independence, we give him back his dignity, and he is able to go out and be a productive citizen, be a member of his family, his society, and he knows he is protected and taken care of.

I oftentimes pity those individuals who do not have the protection that is offered by the Veterans' Administration, because where do those individuals go in a system that is constantly cost conscious?

As a disabled individual, I know there are disabled veterans out there that—and I'm sorry I'm going over, but I think it is an important point—that if we had an aggressive program, we could go out and retrieve those disabled veterans, because there were veterans in the past who have given up, they are too sick, they are too tired, and they are too frustrated to cope any longer with the bureaucracy, and so they wasted away.

So I feel strongly that this is one reason Prosthetics and Sensory Aids Service is important, why it needs to have attention paid to it. Even though it is small in the general scheme of things in our large agency, it is something which we need to develop for the future disabled veterans that I'm so concerned with.

Thank you.

Dr. ROWLAND OF GEORGIA. Thank you for that very forceful, clear, and complete answer to my question. I appreciate it very much.

Mr. Jontz.

Mr. JONTZ. Thank you, Mr. Chairman.

I am sorry that I was not present for Dr. Gronvall's statement, but I have had a chance to review it. I want to ask a question of Dr. Lewis, if I might.

I know that there has been a lot of discussion this morning about the question of pay and the role that pay has in recruiting and retaining nursing staff and other health care professionals. I don't want to take anything away from the importance of that issue, but can you summarize for me what the VA may be doing in terms of addressing the problems relating to working conditions that nurses face?

I know a lot of that is budget related, and as there are cuts in other areas in the staff, nurses end up doing more, and that impacts negatively on working conditions. But it seems to me that we, in the Congress and the VA, have the opportunity to do some innovative things with working conditions for nurses that might be helpful in application in other aspects of our health care delivery system. I wonder if you could briefly address that issue.

Dr. LEWIS. I don't know whether Mr. Haag wants to take this because, again, I think this is one of the issues that his task force has looked at, and perhaps as the head of the office he could respond.

Mr. JONTZ. That would be fine. Thank you.

Mr. HAAG. Thank you.

Yes, certainly working conditions is one of the areas of retention that needs considerable attention. The genesis of my office was the task force that was established back in 1987 that made 24 recommendations as to how to improve the VA's ability to recruit and retain the professional personnel that we employ under title 38; it covers more than just the nurses.

The areas that we feel we can make some impact on are the support areas particularly, areas where the nurses can function at their utmost professional ability in what they have available to them. We have increased our utilization of LPN's and nursing assistants as well as working towards providing other staff support to keep nurses from having to do some of the more administrative and less professional activities.

There are a number of programs that we have been nurturing and hope to pilot. One of them, which has its roots in the VA medical center in Durham, that was proposed by Dr. Tom Luken, is an opportunity to train high school graduates who may have dropped out of school and were motivated to go on and get their GED and their graduation, we would bring them in, train them at the GS-1 or GS-2 level, and give them the opportunity to expand into some of the support areas that would be helpful for the nurses as well as respiratory therapists and physical therapists and things of that sort.

There is also the opportunity to allow the nurses to have more control over their particular areas in their professional life. The VA has very recently established a circular requiring that the chief nurse serve on VA medical center committees that have some policy input.

We also have a lot of activities, individual items being done at hospitals where the nurses have control over their budget. They are provided a budget at the local level, at the ward level, and so on, and support to assist them to make some of the decisions that they have in those areas.

Stress management is another area we hope we will be able to make some inroads on.

But of the 24 recommendations that were made by the task force in 1987, we have things moving on 16 of them, and since our office really didn't come into existence until January of this year, I think we are making some progress.

Mr. **Jontz**. I appreciate the limitations of time, and perhaps it would be possible for you to forward to me a report on the progress. Quite honestly, what I hear from the nurses at home is that developments are heading in just the opposite direction from what you describe. Nurses feel that they have more administrative responsibilities, less control over their professional lives, and I am hopeful that some of the progress that you have described can occur in all the VA health care facilities in this country. Certainly what I hear from nurses at home is quite in contradiction to what you are trying to achieve, and I appreciate the fact that you haven't been there that long, but we are losing good nurses every day, and this is one of the reasons.

Mr. **Haag**. I want to say I was talking more about goals, as to actual accomplishments, and individual hospitals have moved in these directions, and we hope to set up a system where we can share and distribute these functions that may have very well been successful and allow other hospitals to activate those also.

Mr. **Jontz**. Thank you.

Dr. **Lewis**. If I could make comment, if you would like additional information, Ms. Vernice Ferguson, who is, of course, the Director of Nursing Service of the VA, is present in the audience, and, if you would like, we could ask her to come up and address that issue, or else you could talk with her privately about it.

Mr. **Jontz**. My time has expired. I do appreciate your offer.

Dr. **Rowland of Georgia**. Thank you, Mr. Chairman.

Mr. **Morrison**. Thank you, Mr. Chairman.

Let me just pursue one other item, starting with Dr. Lewis, and obviously you can refer this to whoever might know more about it.

I think one of the major missed opportunities in our health care system generally has been the lack of career ladder opportunities for people who enter at lower than the RN level in the nursing area—nursing assistants and LPN's. There was more of it when we had more hospital-based nursing training. We have moved away from that, requiring bachelors' degrees, and perhaps professionalizing in some good ways and maybe some not so good ways the nursing profession, but expanding the gap between nursing assistants and LPN's, and we haven't kept up with that in terms of in-service training and upgrading opportunities for nursing assistants and LPN's.

I wonder what your view on that is, what is the extent to which the VA is interested in that area, whether anyone is working on those kinds of opportunities, because I think the nursing shortage will not be alleviated by money alone, it also involves some broadening of the group of people who ultimately can come into the field.

Dr. **Lewis**. Mr. Chairman, with your permission, I would like to invite Ms. Ferguson up here, because she has some very strong views on the particular issue that you have just addressed.

Dr. **Rowland of Georgia**. That is good.

Dr. **Lewis**. Incidentally, Congressman Morrison, I owe you an apology and an explanation. The question that you asked me earlier about the nursing assistants I misheard. I was addressing this as an LPN issue rather than as a nursing assistant issue. I think we will have to look into this, but I am told that the director does not have discretion in this regard for Saturday premium pay.

The big issue is, of course, a financial issue as well as the impact on other people who are working at the nursing assistant level like the people in SPD and other professionals about what kind of a ripple effect this would have on a hospital budget. But we will try to get back to you with a specific response.

Mr. **Morrison.** Could you specifically write me a letter telling me who has what discretion with respect to premium pay, with respect to nurses, nursing assistants, and LPN's, all of them, so we can put it all in context, because I have been getting quite conflicting answers.

Dr. **Lewis.** Yes, sir.

(Subsequently, the Department of Veterans Affairs furnished the following information:)

The Veterans Health Services and Research Administration will forward a letter to Chairman Montgomery and to Congressman Morrison regarding the flexibility that different levels of VA managers have to approve increased base pay and premium pay for nursing personnel.

Dr. **Lewis.** Ms. Ferguson.

Ms. **Ferguson.** Good morning.

One of the large difficulties that we are now confronting is the limited number of FTEE to do the work. In any health care facility based on Joint Commission standards and all others, a registered nurse must be on duty 24 hours a day, 7 days a week, in every patient care setting. That automatically creams off just seven people to assure that one person is in place on every one of those tours.

If you are confronted, as a chief nurse is, with a limited FTEE, one has to take the most available and the most versatile worker, who happens to be the RN, and unfortunately they are mis-utilized as they do everything from the highest level of activity of responding to sophisticated care and telemetry down to even cleaning up soilage on a floor.

So one of the major issues becomes the limited FTEE with which a chief nurse has to operate and trying to get the most versatile worker.

In addition, we are finding since World War II, when the VA had a large number of nursing assistants, primarily those who had been military corpsmen, join us, recruitment has become more difficult. If you go through any local community in urban America and you do a wage survey, you will discover that the nursing assistant can make more money mopping the floor than being a nursing assistant if you peg it to the salaries of comparable people in the community.

So although many of them remain with us in the system doing magnificent jobs, some have been chosen to take other positions for which they either have more status or more money.

There is some light at the end of the tunnel. My office has worked with the Office of Personnel, and we have developed a new category of health care worker called the health care technician. It is my understanding that in VA Medical Center, Boston, some of these people are in place.

We have to assure that people have the opportunity for greater dignity and status as they do a variety of jobs and a larger salary to go home.

So we are locked in with the GS salary schedule, and some ones of those magnificent nursing assistants of yesteryear who were corpsmen have reached retirement age.

Mr. MORRISON. Mr. Chairman, if I could just follow up.

Dr. ROWLAND OF GEORGIA. Sure.

Mr. MORRISON. I appreciate your statement, but I do have a specific question, and that is, to what extent is any work being done on a career ladder that doesn't start and end with nursing assistant or LPN or RN but integrates all of those jobs with educational opportunity and so forth.

Ms. FERGUSON. We have many of those in place, and the major one that we use is the upward mobility program. In fact, you would be interested to know that the Nursing Service of the VA uses more than 80 percent of all of the money available. There are those who have been nursing assistants who have become LPN's and RN's. These programs are continuing. There are also other people at the medical center who have embraced it. Again, its limitation becomes the available money to put larger numbers of people through.

We have some wonderful programs between academe now and the VA, because they need students while we need the workers, and in some of them we have a quid pro quo in which we don't even exchange money; some of our people teach for free, and they permit our people to have tuition free. We are exploring these all over, and some of those programs are in Mr. Haag's area.

Mr. MORRISON. My time has expired, Mr. Chairman. I would just like to note that as we look at how limited resources can be expended to address this problem, that it may well be that expanding the pool of potential RN's is as cost efficient as raising the pay level of the existing pool, so that it is not either/or but it is some balance between the two, and I would hope that would get some emphasis in our consideration.

Thank you.

Dr. ROWLAND OF GEORGIA. Thank you, Mr. Morrison.

Are there any other Members that have any comments or questions of this panel?

Mr. Kennedy.

Mr. KENNEDY. I would just like to make one comment which has to do with your testimony suggesting that there are simply not enough FTEE positions. One of the things that we have done as a committee is mandate, as you are well aware, Dr. Rowland, specific numbers of FTEE positions in various categories.

So, therefore, it would seem that if there are, in fact, shortages, the question would become, how many of those FTEE positions have actually been filled, as was legislated? It is a question that I think at some point we ought to come back and take a look at, not just perhaps in the nursing area but in general within the VA structure, because those dollars are out there somewhere. I'm not sure what they are being used for at this point. But it does raise the question of what happened between what we legislated and what the money is being spent on.

Thank you, Mr. Chairman.

Dr. Rowland of Georgia. As you point out, Mr. Kennedy, it is not only the nursing area, it is in many other areas that a shortage of professional personnel exists, and it is very difficult to recruit them. It comes down, in most instances, to the lack of money.

Mr. Kennedy. Yes. There is no question about it, Doctor. The only point I was trying to make is that we legislate specific numbers of jobs that they are supposed to go out and hire, and when they don't accomplish that, even if it is because of budget constraints, you would think that we would hear back that these positions were not able to be filled because of the following financial reasons or whatever other reasons might be taken into account, and then we could come back and get a realistic perspective on the kinds of financial constraints that the VA is trying to operate under.

If, in fact, we are just dealing with a situation where the VA is being asked to perform a mission that it is not receiving the necessary financial support for, then that is an issue that this committee ought to struggle with, that we ought to go to bat on in terms of standing up for the VA with the Appropriations Committee.

We heard Members on the other side of the aisle talking about the fact that there is need to stand up to the Office of Management and Budget. It seems that we have got the will on the committee but we have got to work more closely with the VA itself in terms of getting a realistic perspective on whether or not these problems exist.

We just get all this testimony from all the witnesses saying the problems do exist, and then the VA comes in and tries to suggest for some reason that they don't. I just think that if we could work that out a little more gently between the committee and the VA, that we could form the kind of coalition that is necessary to win on these issues.

Dr. Rowland of Georgia. Okay. I thank the gentleman.

Dr. Lewis. May I make a comment just in response to that, Congressman Kennedy?

I think your perspective is right on the mark. The big problem that we have is the mismatch between the mandated personnel ceiling and the amount of money that is available to support that ceiling, and that, of course, is the situation that got us into the bind that we find ourselves in in terms of funding shortfall. We have had to rob accounts such as equipment, such as activations, such as non-recurring maintenance, such as supplies, such as prosthetics that Mr. Downs was talking about, in order to be sure we have been able to maintain that personnel ceiling.

What we have done this year is to let the personnel ceiling float and try to put some of this money back into equipment and NRM accounts, and that, of course, is where we find ourselves at the present time, hopefully waiting for a supplemental.

Mr. Kennedy. So, therefore, what you have done this year is, you have had to reduce the number of employees in order to put money back into prosthetics or any other account.

Dr. Lewis. Yes, sir.

Mr. Kennedy. That is what we are seeing, Doc, when we hear that category A, B, or C veterans are being told that they are not going to receive benefits, they are told that they have to come back for very serious operations and the like, and the fundamental reason, which I am delighted to hear Dr. Lewis say, is because of a financial problem that the VA is not receiving the kind of financial support it should. To tell you the truth, that's the first time I've heard somebody from the VA say that, Dr. Lewis. So thank you very much. That is big progress, in my opinion.

Dr. ROWLAND OF GEORGIA. I thank the panel for being here this morning.

Dr. LEWIS. Thank you.

Dr. ROWLAND OF GEORGIA. I will call the next two panels together, veterans' organizations—Mr. Tom Miller, who is with the Blinded Veterans Association; Mr. Robert Manhan, who is with the Veterans of Foreign Wars; Mr. Frank De George, Paralyzed Veterans of America; Mr. David Gorman with the DAV; and Mr. John Sommer of the American Legion—if you would please come forward.

Gentlemen, I thank all of you for being here this morning, and all of your testimony will be made a part of the record, without objection, and I would ask you, if you will, to summarize to the extent possible.

Mr. Tom Miller, we will ask you to lead off, if you will.

STATEMENTS OF TOM MILLER, DIRECTOR, GOVERNMENTAL AND COMMUNITY RELATIONS, BLINDED VETERANS ASSOCIATION; ROBERT MANHAN, SPECIAL ASSISTANT, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS; FRANK DE GEORGE, ASSOCIATE DIRECTOR OF LEGISLATION, PARALYZED VETERANS OF AMERICA; DAVID W. GORMAN, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; AND JOHN SOMMER, DIRECTOR, VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION, ACCOMPANIED BY SAMUEL WALSH, ASSISTANT DIRECTOR, NATIONAL LEGISLATIVE COMMISSION

STATEMENT OF TOM MILLER

Mr. MILLER. Thank you, Mr. Chairman.

The Blinded Veterans Association appreciates the opportunity to appear this morning before this distinguished subcommittee to present our views on the draft legislation that would amend title 38, U.S. Code, to make certain improvements in veterans health care programs.

I will be brief and summarize and will limit our comments this morning to the draft legislation affecting section 3 of the draft bill that relates to prosthetic services.

Although the Blinded Veterans Association has no opposition and is supportive of codifying the reporting of delays in the ordering of prosthetic services, we have serious reservations as to whether this legislation goes far enough.

In listening to Mr. Downs' comments just a few moments ago, it was obvious that he had all the data available to him and that these kinds of reports have been conducted in the past and are currently being conducted, and the data collected in those reports is available. So I have some concern that codifying this reporting process is going to translate into meaningful change and improvements in the problems that have been chronic for a number of years in prosthetic services and the ordering of those services for our Nation's disabled veterans.

Generally, the two reasons given for the delays are insufficient funding and insufficient FTE to support the activities at the local medical center. Dr. Gronvall, in his testimony, as well as Mr. Downs alluded to the problems that are occurring at the local level, that moneys that have been allocated to a local facility for prosthetic services are being utilized to support other programs and services at that facility.

As I understand it, there is a $10 million shortfall from fiscal year 1988 in terms of prosthetics, that those orders have been pushed into fiscal year 1989. Obviously, there are serious problems with a system where the second week to a quarter the prosthetic representative has to inform a veteran that they are out of money and they cannot submit the order for his device or appliance until the beginning of the next quarter.

BVA is fully aware of the task force on prosthetics that Dr. Gronvall alluded to in his testimony. We concurred with most all the recommendations in there but, again, have reservations as to whether or not they have gone far enough in terms of protecting the funds that have been allocated at the local level for prosthetic and sensory aids.

There is no line item. The money goes into a health care account. The local hospital director has the discretion and the flexibility to utilize those funds for support of whatever programs and services he determines to have the greatest need at any given point in time.

The task force report stops short of recommending a line item in that local budget for prosthetics or even short of fencing that money within that health care account in order to protect it and that those moneys would be expended for purchase of those prosthetic aids and appliances that are so desperately needed by our Nation's disabled veterans.

We feel that something further needs to be done. We recognize the managerial need for flexibility at the local level, but, at the same time, we recognize the need and can identify very closely with the need for having prosthetic aids and appliances on a timely basis.

In response to Mr. Downs' comments, we would, I think, support and identify very closely with those he has identified, the major problems that exist, and I think he also has identified another problem that we have identified in the past related to blind rehabilitation services in the VA central offices, that it has program responsibility but very little, if any, program authority. But, obviously, Mr. Downs has a handle on what the problems are out there but does not have the authority or the tools to correct those problems in order to approve the services which he is responsible for delivering.

Finally, I would like to comment on section 614. The proposed legislation would add to subsection (a), number 2, the reporting. Subsection (b), which addresses the provision of dog guides for blinded veterans and also for high technology equipment, and particularly computers. This is an area which would not be addressed by the proposed legislation, and it is one where there is great need.

In any reform of the funding and establishment of FTE for prosthetic services and appliances, we feel serious consideration has to be taken for the provision of computer-accessible equipment for the blind and the evaluation and training on such equipment for our veterans. Blind Rehab Service in VA Central Office has submitted an excellent program to address those needs, and we have, for several years now, called for funding in support of that program, but all new initiatives, because of budget constraints, have not been positively or favorably ruled on. We would encourage that this also be considered in any legislation that would address the prosthetic needs of our Nation's veterans.

Finally, I would like to thank you, Mr. Chairman, for this opportunity this morning, and, as always, we would be pleased to answer any questions you might have.

[The prepared statement of Mr. Miller appears at p. 118.]

Dr. ROWLAND OF GEORGIA. Thank you, Mr. Miller.

Mr. Manhan.

STATEMENT OF ROBERT MANHAN

Mr. MANHAN. Thank you very much, Mr. Chairman.

The VFW realize that all of these problems address the issue of improving management within the DAV's health care service for veterans. With that, we address Mr. Kennedy's bill, H.R. 1199 first. We notice that it deals exclusively with registered nurses. It did have a refreshing approach by allowing flexible starting pay, and it did have a decentralized compensation system, which is something that doesn't exist. We would very much appreciate working with this subcommittee if you wanted to pursue that course any further.

Then we immediately address Chairman Montgomery's bill, H.R. 901. We notice that title I dealt primarily with personnel provisions. We certainly endorse his sections 101 and 102 because they address all aspects of the nursing career field—registered nurses, licensed practicing nurses, as well as nurses' assistants. Coupled with that was the proposal to expand title 5 or the ability for title 5 employees to seek outside non-VA jobs—compensation. We think that is a reasonable approach provided there is no conflict of interest, of course.

Then last was the proposal to allow the VA, a Federal agency, to hire retired military nurses and have those people not lose their Armed Forces retirement pay if they elected to join another Government agency. This is certainly an untapped source of perhaps critically needed nursing skills.

Then we noticed that title II dealt with health care amendments. We certainly supported the extension of the respite care program. In fact, it is now going to be a permanent program. We also very much applauded the action this committee has taken to extend by 3 years the State Home Grant Program to September 1992. We certainly recognize that our old, old veterans need all the help they can get regarding domiciliary and/or nursing home care.

The last part of that was Chairman Montgomery's section 202, the homeless veterans. We support the half-way house concept to help return to society as a productive member those homeless veterans who can be returned with a lesser amount of care and cost to the VA system. Coupled with that were two positive actions in what is called the Compensation Work Therapy Program, CWT. We support both of them particularly, especially the ability for homeless veterans to obtain housing at a discount through the VA.

Chairman Montgomery's title III portion was health care management. We like the concept of a pilot program for 2 years. We realize that that is going to uncover an awful lot of problems that must be addressed positively by the DVA. They are going to find out that they have many of the problems that the Social Security Administration has when you try to put people on computers and try to account for moneys. But we did approve the pilot concept.

Then we went to section 302, which is the eligibility of DOD dependents to receive mandated health care in the DVA system. Mr. Chairman, at this time, we were concerned with that approach. We felt that perhaps we couldn't support it for two reasons: First, primarily, because DVA is unable, unfortunately, to provide all the entitled care to all veterans at this time for funding problems; second, we believe that there is enough positive language in title 38 that would allow the chairman to do what he wants to do on a case-by-case basis, mutual agreement between a coexisting DOD medical facility and a DVA facility.

Last, we address the CHAMPVA action under health care management. Absolutely, we support that 100 percent. We want those dependents and/or surviving spouses who are entitled to VA moneys for health care to receive them. Conversely, we would not like to think that those people who are not entitled to VA moneys are receiving them. That is a positive step.

Last is the issue of the Veterans' Administration canteen service. We support this concept—and I quote—"The VFW is most interested in providing the largest selection of merchandise and/or service in a clean, courteous, and congenial atmosphere for those veterans who are confined either for a medical disability and/or old age domiciliary or a nursing home care problem." If it takes greater centralized control to meet these goals, then we support the change.

[The prepared statement of Mr. Manhan appears at p. 128.]

Dr. ROWLAND OF GEORGIA. Thank you, Mr. Manhan.

Mr. De George.

STATEMENT OF FRANK DE GEORGE

Mr. DE GEORGE. Good morning, Mr. Chairman and members of the subcommittee.

Paralyzed Veterans of America appreciates this opportunity to present our views regarding the introduction of legislation pertaining to the recruitment and retention of nurses in the Department of Veterans Affairs and for other stated purposes.

To begin, PVA supports, section by section, every measure contained in the agenda for today. I will address specific areas at this time.

H.R. 901, if enacted, would significantly improve the Department of Veterans Affairs' ability to recruit and retain nurses and other hands-on health care personnel. The provisions included in this legislation would go a long way in relieving the critical shortages being experienced by DVA medical centers in this important health care field.

As it regards special pay for nurses, PVA supports and firmly believes that the incorporation of special pay for nurses is critical in the overall enhancement of the nursing programs. The DVA can only attract and retain these individuals if they are properly compensated for their expertise and special abilities.

By addressing such issues as tenure, overtime, professional expertise, and other special attributes, you have properly included these individuals in the highly qualified category along with physicians and dentists. This measure will go far to assist in correcting the most serious problem facing the DVA, which is the lack of adequate staff. We applaud the efforts of Chairman Montgomery for introducing this measure. Meanwhile, we must ask the question and continue to seek the answers, where are the agency's staffing guidelines?

As it pertains to H.R. 1199, PVA also supports the provisions contained in this measure. This measure, in conjunction with H.R. 901, provides meaningful incentives that encourage the recruitment and retention of nurses. It also enhances the potential for career opportunity, as discussed earlier, while recognizing time and grade longevity of the professional health care personnel. Especially important in this provision is for the inclusion of geographic cost-of-living paid differentials.

Mr. Chairman, both H.R. 901 and H.R. 1199 take positive steps to enhance DVA recruitment opportunities in the areas of nursing and other medical personnel. Paralyzed Veterans of America strongly endorses both initiatives since we believe the bills complement each other and there does not appear to be any conflict between the two.

Merger of these two bills, if enacted, would greatly strengthen the DVA's position when competing within the medical community to recruit and retain nurses and other hands-on medical personnel. PVA is especially grateful to Chairman Montgomery and to Representative Joseph Kennedy and the many cosponsors who have endorsed these two pieces of legislation. Your combined efforts will ultimately result in better health care for our Nation's veterans.

Dr. **ROWLAND OF GEORGIA.** Thank you, Mr. De George.

Mr. **DE GEORGE.** I have just a few more comments, sir.

Dr. **ROWLAND OF GEORGIA.** You do.

Mr. **DE GEORGE.** Regarding eligibility of military dependents for health care under sharing agreements, we just want to make one point that, while we are supportive, we must state that our concern is with the ever increasing demand for health care services made on DVA by aging veterans. Providing quality of care to veterans is a priority that must never be jeopardized, because DVA is spread too thin due to the inclusion of additional groups of eligible beneficiaries. Also, priority medical care for veterans must not be jeopardized by the treatment of dependents whose care could be paid for or will be paid for by the Department of Defense.

Having made these statements, we reiterate our support for this amendment, and thank you, Mr. Chairman.

[The prepared statement of Mr. De George appears at p. 131.]

Dr. Rowland of Georgia. Thank you, Mr. De George.

Mr. Gorman.

STATEMENT OF DAVID W. GORMAN

Mr. Gorman. Thank you, Mr. Chairman. Good morning. It is always a pleasure to appear before this committee.

I have submitted our written testimony for the record, and what I would like to do is limit my oral comments to four specific issues, if I can, the first being those provisions of H.R. 901 dealing with registered nurses and licensed practical nurses, and also Mr. Kennedy's bill, H.R. 1199.

I think it is comforting to see, and we are delighted to see, the subcommittee's continued interest in the nursing shortage facing the Veterans' Administration. I think that enough testimony has been heard and the issue has been around long enough that it is a real issue, and I think Mr. Bilirakis made an excellent point as far as the burn-out factor of nurses within the system.

We are supportive of the provisions of both H.R. 901 and Mr. Kennedy's bill, H.R. 1199, as far as the flexibility provided to the local hospital directors on a facility-by-facility basis to go ahead and do something to provide adequate salaries and increases in salaries to nurses. We are appreciative of both those measures.

As we understand it, Mr. Chairman, section 202 of H.R. 901 would authorize the sale for an amount of not less than 75 percent of the fair market value of difficult-to-sell foreclosed properties to certain nonprofit organizations to use as transitional housing assisting homeless veterans who are participants in the Compensated Work Therapy Program administered by the VA.

The DAV is concerned somewhat with the difficulties and the challenges now facing the Loan Guarantee Program, and we are somewhat concerned that the Department make every effort to utilize all possible means to dispose of those properties in a manner which will benefit the Government and, most importantly, veterans, while not further compromising in any degree the integrity of the Loan Guarantee Program.

We would suggest that if this measure receives favorable consideration by the subcommittee, implementation be accomplished in a slow and cautious manner. In that regard, we would suggest the most favorable way to achieve that would be via the creation of a pilot program.

Mr. Chairman, the DAV very strongly supports section 302 of H.R. 901 extending eligibility to depends of Department of Defense beneficiaries to receive health care services on a space-available basis in VA medical facilities which have active VA and DOD sharing agreements.

As you are aware, the DAV has proposed and strongly advocates enhanced sharing capabilities between the VA and DOD. It is our strong belief that the creation of a health care alliance between these two Federal departments would only allow both to make the best use of scarce medical services, thereby resulting in ongoing cost avoidances while providing quality medical care to the largest number of entitled beneficiaries possible.

Finally, Mr. Chairman, section 3 of draft legislation proposes, in part, that the Secretary, not later than February 1 of each year, be required to submit a report to the Veterans' Affairs Committees on *the delays in furnishing* of prosthetic services which occurred during the preceding fiscal year. The DAV wholeheartedly endorses this provision.

For the last 8 years, Mr. Chairman, the DAV has been engaged in an active and an ongoing dialog with the VA regarding the prosthetic and sensory aids service as well as research efforts of the VA relating to prosthetic devices. Spanning this time frame, we have witnessed positive changes regarding the manner in which prosthetic services have been administered and delivered to this most deserving and disabled category of veterans. Regrettably, more needs to be done still. We refer specifically to the manner in which prosthetic limbs and devices are delivered or, in many cases, not delivered in a timely fashion to disabled veterans.

During fiscal year 1987, the number of prosthetic orders backlogged simply for lack of funding totaled some 5,200. At the end of fiscal year 1988, that number had risen to 7,552, approximately a 45-percent increase. Less than 6 months ago, a task force comprised entirely of VA employees released a report of findings and recommendations after only two meetings on the subject. Their findings were clear and convincing, however, that something must be done to correct a situation that is clearly becoming grossly intolerable to disabled veterans.

As Mr. Downs indicated earlier, some of the findings of that task force indicated a shortfall of $10.5 million in fiscal year 1989 can be expected. That will only serve to exacerbate and increase the backlog of orders for prosthetic devices. That task force also recommended that an additional 83 full-time employees are required for marginally acceptable field operations in the delivery of prosthetic services.

Finally, 21 VA medical centers were identified that did not have a prosthetic service, and they were clearly indicated to have shown a documented need for the establishment of such a service.

Mr. Chairman, all indications the DAV has are that the situation will not improve, and, conversely, we sense the situation will only worsen considerably over the remainder of this fiscal year and into the future.

That concludes my statement, Mr. Chairman. Thank you.

[The prepared statement of Mr. Gorman appears at p. 135.]

Dr. ROWLAND OF GEORGIA. Thank you, Mr. Gorman.

Mr. Sommer.

STATEMENT OF JOHN F. SOMMER

Mr. SOMMER. Thank you, Mr. Chairman.

It is obvious to the American Legion that recruitment and retention of health care personnel is a problem which begs for a permanent resolution if the VA is to continue its mission of providing quality health care and medical services for the Nation's eligible veterans.

The amendments set forth in both title I of H.R. 901 and H.R. 1199 are commendable and demonstrate both a need for improvement in the ability of VA to recruit and retain nurses and a commitment on the part of the authors of the bills to initiate these needed improvements.

The provisions of H.R. 1199 appear to give greater latitude to the medical center directors to immediately establish more competitive wages for nurses. We strongly support the amendment set forth under section 102 of H.R. 901 which would authorize the provision of premium pay for licensed practical or vocational nurses and nurse assistants.

We are hopeful that a package consisting of the recently reinvigorated Nurse Scholarship Program and the tuition reimbursement under Public Law 103-22, combined with a salary and benefit improvement plan drawn from the legislation under consideration today, and the recommendations emanating from the agency will provide VA with the ability to be competitive in order to better be able to recruit and retain qualified nurses.

The Legion supports the repeal of the expiration date of the Respite Care Program and the extension of the State Home Grant authority provided under section 201 of H.R. 901. We do not support the pilot program under section 301 for the administration of fees. The Legion continues to oppose the means test and third-party reimbursement as they apply to VA medical care by national convention mandate. To support a method by which to collect moneys emanating from the reimbursement provisions of these issues would fly in the face of our mandate.

Section 302 of the bill relates to eligibility of military dependents for health care under sharing agreements, and the American Legion cannot support the provision of medical care to non-veteran dependents when we now have almost all category B and C veterans and some non-service-connected veterans in category A being denied medical care in the VA facilities.

With respect to the draft legislation, we fully support section 1, which would restore the provisions of 38 CFR 17.51 so as to rescind the limitations that have been placed on community nursing home contracts. We support section 2 of this draft measure relating to the reports emanating from the Geriatrics and Gerontology Advisory Committee; and, finally, we strongly support section 3, which we trust would alleviate the delays in the ordering of prosthetic appliances. Our experience is that these delays have primarily resulted from shortages of prosthetic funding at the medical center level.

Mr. Chairman, that completes our summary.

[The prepared statement of Mr. Sommer appears at p. 139.]

Dr. ROWLAND OF GEORGIA. Thank you very much.

Would either of you gentlemen, Mr. Kennedy or Mr. Bilirakis, have any questions of this panel?

Mr. KENNEDY. No, thank you.

Dr. ROWLAND OF GEORGIA. Any questions, Mr. Bilirakis?

Mr. BILIRAKIS. No, Mr. Chairman.

Dr. ROWLAND OF GEORGIA. Very good. I want to thank the panel then. We have a vote on here, and what we will do is go and vote and come back immediately and then hear the last panel. Let me thank all of you very much this morning for your testimony here.

[Recess.]

Dr. **Rowland of Georgia**. I would ask the committee to please come to order.

The last panel is here. I would ask Ms. Irene Lussier, a member of the American Nurses' Association, and Ms. Claudette Morrissey, president of the Nurses Organization of the VA, to please come to the witness table.

Thank you for your patience and also for being here this morning. Ms. Lussier, we will ask you if you will proceed first, and your full testimony will be made a part of the record, without objection, and we ask you to summarize to the extent that you can.

STATEMENTS OF IRENE M. LUSSIER, R.N., MEMBER, AMERICAN NURSES' ASSOCIATION, ACCOMPANIED BY DONNA RICHARDSON, DIRECTOR, CONGRESSIONAL AND AGENCY RELATIONS; AND CLAUDETTE MORRISSEY, R.N., PRESIDENT, THE NURSES ORGANIZATION OF THE VA, ACCOMPANIED BY NOREEN SOMMER, R.N., LEGISLATIVE CHAIRPERSON

STATEMENT OF CLAUDETTE MORRISSEY, R.N.

Ms. **Morrissey**. I'm sorry, I thought you were referring to the other lady.

Good morning, Mr. Chairman and members of the subcommittee. I am Claudette Morrissey, a registered nurse employed full-time as a staff nurse at the Brooklyn VA Medical Center. I am accompanied today by Ms. Noreen Sommer, who works full-time. She is NOVA's legislative director, and she works full-time as a community health nurse in the field of spinal cord injury at Palo Alto, California. I come to speak today as president of the Nurses Organization of the Veterans' Administration.

Mr. Chairman, we appreciate the outstanding efforts of you and your committee in supporting solutions to the present nursing shortage within the VA medical care system. Last year, NOVA was pleased to support the legislation originating in this committee that attempted to stop the hemorrhage of nurses from the system by implementing bonuses for tenure, full-time work, head nurses, and for highly qualified nurses with specialty certification, and we do support that today.

As we stated then, our caution was that discretionary bonuses without adequate funding do not get implemented. We believe that the solution to maintaining salaries comparable to community rates rested in a revision of the basic pay rates for all VA registered nurses. It was our belief then and continues to be NOVA's belief now that discretionary bonuses on top of inadequate base salaries are necessary but are only a short-term remedy and that raising the denominator of base salaries is a necessity.

It is for this reason that our members were pleased to see that H.R. 1199 has so many of the elements that have been shown to be important approaches to overcoming the historical financial compensation disincentives in the nursing profession. It has built upon the strength of the current VA nurse pay schedule which does reward experience, education, and performance. It is consistent with the recommendations of the Secretary of Health and Human Services' Commission on Nursing, which included a recommendation to expand nurses' pay ranges and have pay scales reflect the different levels of experience, performance, and education.

It is also our understanding that this legislation will continue to allow for the use of special salary rates in excess of the maximum rate in those truly special instances in which the maximum rate is not competitive with the local community. We believe that this will restore the meaning of "special" to "special rate" rather than having it be the standard, as it is now, for when 120 of the 172 VA medical centers are using special salary rates, they can hardly be deemed special.

NOVA was gratified to hear that the issue of the overtime pay cap would be addressed in this legislation, for it is one that our members have brought to our attention frequently, because it seems to defy their belief in common sense and fair play. The overtime rate is currently limited to one and a half times the usual hourly rate of pay until the maximum of $20 per hour is reached. Thus, a nurse who was full grade step 5 receives one and a half times the hourly rate. This percentage is gradually reduced for each step until senior grade step 7, where the nurse would, in fact, make less at the overtime rate than at their regular rate.

The resulting situation is that the overtime rate is so unfair, nurses resist working overtime and are, instead, frequently given compensatory time, one hour off for one hour of time worked. Not only does this process conceal the amount of overtime that is needed to staff the hospitals, it contributes to a continual shortage of staff available to care for patients if the registered nurses take the comp time to which they are entitled.

We ask the support of all the members of this committee to approve the approaches reflected in H.R. 1199. Additionally, we would ask the assurance of this committee that this legislation will be accompanied by an appropriation request that will make it possible for directors of medical centers to use the pay step flexibility to recognize the outstanding performance and accomplishments of nurses.

On behalf of these nurses, I wish to thank you, Mr. Chairman, for the opportunity to appear before you today. NOVA commends this committee for what you have done thus far to improve VA competitiveness, and we pledge to continue working with Congress and the Department of Veterans Affairs to assure that our veterans receive the care they need and desire.

[The prepared statement of Ms. Morrissey appears at p. 151.]

Dr. **Rowland of Georgia**. Thank you, Ms. Morrissey.

Ms. Lussier.

STATEMENT OF IRENE M. LUSSIER, R.N.

Ms. **Lussier**. Mr. Chairman, I am Irene Lussier, a psychiatric staff nurse at the Albany Veterans' Administration Medical Center. I am also chairperson of the Nursing Retention Committee there. With me is Donna Richardson, director of congressional and agency relations at the American Nurses' Association. I appear today as a member of the American Nurses' Association, which has represented VA nurses in collective bargaining since 1967 through its State nurse associations.

All is not well in VA hospitals. If the VA health care system were a patient, we would describe its condition as critical. Meaningful measures must be taken. We would like to thank the committee's continued commitment to quality health care for veterans and improving working conditions for nurses. Hospitals, including the VA, are facing a critical nursing shortage at the same time the VA is facing an influx of older and sicker patients. The needs of those patients require the care of a registered nurse.

VA hospitals were in the forefront of nurses' salaries, benefits, education, and professional development. However, the private sector can respond to market demands faster than the VA, especially in nursing recruitment and retention. Pennsylvania VA hospitals have no budget money for recruitment. The nurses have funded their own recruitment events. Many VA's have closed beds and units due to the inability to supply nurses. Budgetary reductions have also resulted in a reduction in nurse mix in several VA hospitals.

Illinois and California VA hospitals report freezes in employment of RN's and licensed practical nurses. Several hospitals have reduced their RN ceiling. Nurses are being rotated to specialty units without sufficient orientation. Managers have been instructed to increase non-RN staff to make up for RN reductions. This occurs while high LPN/LVN vacancies and turnover and reductions in LPN/LVN ceilings exist. The VA cannot compete with the private sector for LPN's. A decrease in RN's means that the VA will use more numbers of lower skilled employees to provide health care. Veterans may be deprived of essential life-preserving care and treatment.

The proposed budget will provide no funding for the revision of RN pay scales. Previous shortfalls have resulted in RN and support cutbacks and corresponding reductions in services for veterans.

Nursing staff and support salaries must be increased. At least 3,000 beds are reportedly closed due to nursing shortages. Computer assistance for nursing is nil. The VA's in Cincinnati, and Louisville, and Lexington, Kentucky, have hired nurse recruiters. Nurses complain they cannot attend continuing education programs because of staff shortages. These conditions do not provide enticements for recruiters.

ANA has reviewed H.R. 1199 and endorses the bill. We have repeatedly stressed the VA's inability to compete with private sector salaries. We believe restructuring of nurse grades is necessary and long overdue. Such changes must address the long-term VA nurse also. The VA must recognize nurses with additional skills and experience, as outlined in section 3(a). However, we must stress that the nursing salary structure, which should be even higher, is not the only issue. Appropriate support staffing must be provided.

We have also reviewed H.R. 901. ANA has supported Federal special pay provisions which permit the VA to compete with the private sector. We are concerned about the complexity of the program's implementation and lack of budget allocations. However, something must be done immediately.

We support the intent of section 101 but are concerned that the specialty service differential may cause morale problems. Utilization of incentive special pay must be flexible to apply to medical surgical nurses as well. We wonder if the specification of dollar amounts allows for future inflation.

We applaud the provisions in this bill and in H.R. 1199 which provide incentives for head nurses. However, we believe the VA must be competitive with more than remuneration to keep head nurse material.

We support section 102 which would provide premium pay to LPN's and nursing assistants. We are disappointed that clarification of outside employment extends only to title v employees and not to RN's.

We must reiterate our statement on the fiscal year 1990 VA budget. It is insufficient to meet current services. The VA medical care program cannot continue to absorb the costs of pay raises and special pay. Congressionally mandated funds for personnel costs must be provided.

Staff nurses believe that they have been kept in the dark about application of recruitment and retention policies. The VA must consider timely and effective ways to inform its nurses.

Lastly, and importantly, nursing's ability to engage in effective collective bargaining must be maintained because it impacts health care personnel retention and recruitment within the VA medical system. The National Labor Relations Board's recent decision to recognize all our bargaining units in the private sector means that the VA will have to compete even more vigorously in meaningful contracts as well as salaries and benefits.

Thank you for the opportunity to address recruitment and retention issues that affect veterans' health care. We will continue to work with Congress and the VA to provide the nurses necessary to care for veterans.

[The prepared statement of Ms. Lussier appears at p. 160.]

Dr. ROWLAND OF GEORGIA. Thank you, Ms. Lussier.

Mr. Kennedy.

Mr. KENNEDY. Thank you, Mr. Chairman.

First of all, I would like to just commend, really, all four of you and the thousands of people that you represent for the tremendous work that they do each and every day for our Nation's veterans. The fact is that for many years now you have been performing that work without being compensated in the way that you ought to be.

Up in my own home State of Massachusetts, we find hundreds of people that come to my office who are, in fact, suffering as a result of the inability of the VA to provide the kind of patient care that they were designated to set up and do, and in most cases there is a direct correlation between the lack of available care and the incapacity of the VA to go out and hire nurses at competitive rates. It is a problem that is found in many places throughout the country, and I am delighted to hear the kind of support that you would provide for the legislation that I have filed.

I think that it is very important that we recognize that last year we had legislation which passed through this committee, and yet when it ran into the Senate side we hit some significant problems. So I would hope that all of you would be willing to work hard, particularly on the Senate side, to point out the very real problems that nurses face and to, in addition, point out that this year the legislation adjusts the capability of the individual managers to make adjustments where they are necessary and to keep the overall costs to the VA down where that is possible.

So, as I said, I am delighted to hear of your support. I also want to commend you for the tremendous work that you do on behalf of our Nation's veterans and, really, for all Americans across our country.

Thank you very much, Dr. Rowland.

Dr. **Rowland of Georgia**. Thank you, Mr. Kennedy.

Mr. Bilirakis, would you have a comment or question?

Mr. **Bilirakis**. Thank you, Mr. Chairman. I appreciate your indulgence.

The question that I would pose—and, really, I am not sure it requires an answer at this time—getting back to the points that I have been trying to make, the burn-out and things of that nature, I wonder if very briefly you could maybe talk on that subject. When I say "burn-out" and when we talk alcoholism and drug use, to me, at least, many of them are associated with burn-out, so I think they are probably somewhat related. Would you like to talk on this subject insofar as our nurses are concerned and, in the process, let me know if you have had any personal experiences. I don't mean as patients, but I mean from the standpoint of talking with veterans who are patients who experience the problems, and I would like to hear any recommendations that you may have also towards that end.

Ms. **Sommer**. From the point of view of our organization and also myself personally, I have not had any experience with an impaired nurse or with our membership or nurses contacting us about this being a particular problem. That is not to deny that there is not any kind of problem, but it has not been a major one or one that people are bringing to our attention.

In general, we try to maintain sort of an optimistic attitude about performance. It is hard to improve the image of the VA and entice people to come and work and recruit friends and people to come if you are acting and talking like a burned out nurse, but, in reality, there is a problem, and each time a nurse leaves and the ward is going to be short-staffed based on that person leaving, I think it takes a piece of each person that is left to fill that job and trying to stretch and provide the care. I think that is true.

Mr. **Bilirakis**. But Dr. Gronvall—and not meaning to put words in his mouth—sort of acknowledged that there have been incidents. They may be isolated, and if they are, that is just part of the real world.

Ms. **Sommer**. I am personally or organizationally unaware of that.

Mr. **Bilirakis**. You are not personally familiar with it.

Ms. **Richardson**. The American Nurses' Association agrees with Dr. Gronvall in stating that substance abuse, both drug and alcohol, is a problem. It is a problem throughout our Nation. Nurses, and physicians, and other health care workers are not exempt from that problem. The evidence that we have been able to find shows that it is not a major problem within the VA system, that it is minuscule.

Our association and our State associations have for years promoted rehabilitation of those nurses who do have problems with drugs and alcohol.

Mr. **Bilirakis**. Are you being listened to? Forgive me for interrupting. Are you being listened to? You say you have been promoting it for years.

Ms. **Richardson**. We have been promoting it for years, because substance abuse is not anything new, it has been there for years.

The major problem that seems to be overlooked because people are concerned about hard drugs is alcohol, and we have promoted rehabilitation programs for a number of years, including employee assistance programs. We are concerned that, with the nursing shortage and with the additional strain on managers and supervisors and on the staff nurse, that that is not what causes the substance abuse, but it may affect the ability of the manager to determine if, indeed, such problems exist, because they should be able to look at a person's work, at their absenteeism, at their tardiness, at how their performance has gone downhill, and to determine that there is a problem, and then be able to determine if it is substance abuse, or divorce, or it is burn-out, and then have the ability to utilize the employee assistance programs that are there.

The VA as well as the other Federal agencies are supposed to develop drug testing programs, and we have taken the position that they shouldn't be random or mandatory but it should be based upon the ability of the system to determine who may be a substance abuser.

With regard to burn-out, one of the major problems is that when a nurse realizes that she is tired, that she may be suffering from burn-out, and that she wants to take her annual leave, which she is entitled to, she may not be able to take it because of staff shortages. That is a problem.

So I think the real problem is the fact that the nursing shortage impacts the ability of the system to respond when their employees do need help with burn-out or substance abuse.

Mr. **Bilirakis**. So what you are basically saying, and I'll be very brief, Mr. Chairman—is that you think the nursing shortage probably contributes to these other problems, but you don't think that these other problems contribute to the nursing shortage.

Ms. **Richardson**. That is correct.

Mr. **Bilirakis**. Thank you.

Thank you, Mr. Chairman.

Dr. **Rowland of Georgia**. Thank you, Mr. Bilirakis, and I thank all of you for being here this morning. I thank you for your commitment and your dedication, because in the face of the budget constraints that we have had and the shortage of personnel, the only reason that we still continue to have the high quality of medical care that we have in our Veterans' Administration hospitals is because of the dedication that the people like you have. So thank you very much for being here this morning.

You seem to be moving towards the microphone as though you want to say something.

Ms. **Sommer**. There was one piece of information that one of our members gave us last night that was very frightening to me, and I wanted to just share that with you. This is only at one hospital, but they did a survey of the average age of the number of nurses at their hospital. The average age of the RN at the hospital was 46 years old; 50 percent of the nurses working at that institution are eligible for retirement within 5 years. So if this is in any way representative, and I am not necessarily saying it is, but it was so shocking to me that I just felt it was an important piece of information to share with you and something that we will certainly look into further.

Dr. **ROWLAND OF GEORGIA**. Well, that certainly is unsettling.

Thank you again for being here today.

The hearing stands adjourned.

[Whereupon, at 12:00 noon, the subcommittee was adjourned.]

APPENDIX

I

101st CONGRESS
1st Session

H. R. 901

To amend title 38, United States Code, to improve programs for the recruitment and retention of health-care personnel of the Department of Veterans' Affairs, to extend certain expiring programs of that Department, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

February 7, 1989

Mr. **Montgomery** (for himself, Mr. **Hammerschmidt**, Mr. **Stump**, Mr. **Evans**, Mr. **Wylie**, Mr. **Penny**, Mr. **McEwen**, Mr. **Staggers**, Mr. **Rowland** of Georgia, Mr. **Smith** of New Jersey, Mr. **Florio**, Mr. **Ridge**, Mr. **Robinson**, Mr. **Rowland** of Connecticut, Mr. **Stenholm**, Mr. **Harris**, Mr. **Jontz**, Mr. **Payne** of Virginia, Mr. **Parker**, Mr. **Jones** of Georgia, Mr. **Leath** of Texas, Mr. **Hefner**, Mr. **Richardson**, and Mr. **Jenkins**) introduced the following bill; which was referred to the Committee on Veterans' Affairs

---

A BILL

To amend title 38, United States Code, to improve programs for the recruitment and retention of health-care personnel of the Department of Veterans' Affairs, to extend certain expiring programs of that Department, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; REFERENCES TO TITLE 38, UNITED STATES CODE; DEFINITION OF SECRETARY.

(a) SHORT TITLE.—This Act may be cited as the "Veterans' Health-Care Programs Amendments of 1989".

(b) REFERENCES TO TITLE 38.—Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

(c) SECRETARY DEFINED.—For purposes of this Act, the term "Secretary" means the Secretary of Veterans' Affairs.

TITLE I—PERSONNEL PROVISIONS

SEC. 101. SPECIAL PAY FOR NURSES.

Section 4118 is amended as follows:

(1) The heading is amended to read as follows:

"§ 4118. Special pay for physicians, dentists, and nurses".

(2) Subsection (a)(1) is amended—

(A) by striking out "physicians and dentists" after "highly qualified" and inserting in lieu thereof "physicians, dentists, and nurses";

(B) by striking out "physician or dentist" both places it appears and inserting in lieu thereof "physician, dentist, or nurse"; and

(C) by inserting after clause (B) the following: "or (C) $[illegible],000 per year to any nurse so employed on a full-time basis (or in the case of a nurse employed on a part-time basis, a proportional amount of the maximum benefit that would be paid under this section to such nurse if such nurse were employed on a full-time basis, calculated on the basis of the proportion which the part-time employment of such nurse in the Veterans' Health Services and Research Administration bears to full-time employment)".

(3) Subsection (a)(2) is amended by striking out "physician or dentist" and inserting in lieu thereof "physician, dentist, or nurse".

(4) Subsection (a)(3) is amended by striking out "and dentists" both places it appears and inserting in lieu thereof ", dentists, and nurses".

(5) Subsection (b) is amended—

(A) in paragraph (2), by inserting "or $1,500 to any eligible full-time nurse," after "dentist,"; and

(B) in paragraph (3)—

(i) by inserting "or of $1,500 to any eligible part-time nurse," after "dentist," the first place it appears; and

(ii) by striking out "physician or dentist" and inserting in lieu thereof "physician, dentist, or nurse".

(6) Subsection (c) is amended—

(A) by redesignating paragraph (5) as paragraph (7); and

(B) by inserting after paragraph (4) the following new paragraphs:

"(5) In the case of eligible full-time nurses appointed under this chapter, the Secretary shall provide, in addition to the primary special pay provided for in subsection (b)(2) of this section and in accordance with regulations prescribed to carry out this section, incentive special pay of not more than $5,500 to any eligible nurse. In prescribing such regulations to carry out this paragraph, the Secretary shall take into account only the following factors and may pay no more than the following per year amounts of incentive special pay to any full-time nurse eligible for such pay:

"(A) For tenure of service within the Veterans Health Services and Research Administration of two years or more but less than five years, $500.

"(B) For tenure of service within the Veterans Health Services and Research Administration of five years or more, $1,000.

"(C) For service in intensive care units, critical care units, emergency rooms, or operating rooms or in a nursing specialty with respect to which the Chief Medical Director has determined that there are extraordinary difficulties in the recruitment or retention of qualified nurses, $4,000.

"(D) For service in a specific geographic location with respect to which the Chief Medical Director has determined, pursuant to such regulations, that there are extraordinary difficulties in the recruitment or retention of qualified nurses, $1,500.

"(E) For service in a head nurse position $1,500.

"(6) In the case of eligible part-time nurses appointed under this chapter, the Secretary shall provide, in addition to the primary special pay provided for in subsection (b)(3) of this section and in accordance with regulations prescribed to carry out this section, incentive special pay of not more than $5,500 to any eligible nurse. In prescribing such regulations to carry out this paragraph, the Secretary shall take into account only the following factors and may pay no more than a proportional amount of the following per year amounts of incentive special pay to any nurse eligible for such pay, which proportional amount shall be calculated on the basis of the proportion which the part-time employment in the Veterans Health Services and Research Administration of such nurse bears to full-time employment:

"(A) For tenure of service within the Veterans Health Services and Research Administration of two years or more but less than five years, $500.

"(B) For tenure of service within the Veterans Health Services and Research Administration of five years or more, $1,000.

"(C) For service in intensive care units, critical care units, emergency rooms, or operating rooms or in a nursing specialty with respect to which the Chief Medical Director has determined that there are extraordinary difficulties in the recruitment or retention of qualified nurses, $4,000.

"(D) For service in a specific geographic location with respect to which the Chief Medical Director has determined, pursuant to such regulations, that there are extraordinary difficulties in the recruitment or retention of qualified nurses, $1,500.

"(E) For service in a head nurse position $1,500.".

(7) Subsection (d) is amended—

(A) by striking out "physician or dentist" each place it appears and inserting in lieu thereof "physician, dentist, or nurse"; and

(B) by striking out "or (c)(4)(C)" and inserting in lieu thereof ", (c)(4)(C), (c)(5)(D), or (c)(6)(D)".

(8) Subsections (e)(1) and (e)(2) are amended by striking out "physician or dentist" each place it appears and inserting in lieu thereof "physician, dentist, or nurse".

(9) Subsection (e)(4) is amended by adding at the end the following new subparagraph:

"(D) any nurse who becomes employed in the Veterans Health Services and Research Administration after the date of the enactment of this subparagraph and who enters into an agreement under this section is entitled to special pay beginning on the date on which the agreement is entered into, or the date on which the nurse becomes employed, whichever date is later.".

(10) Subsection (e) is further amended by adding at the end the following new paragraphs:

"(5) An agreement may only be entered into with a nurse under this section if the nurse is a registered nurse and is an employee of the Veterans Health Services and Research Administration whose duty assignments involve direct patient care.

"(6) A nurse who is eligible for additional pay under section 4107(g)(1) of this title and special pay under this section may not receive such special pay under this section unless the nurse waives receipt of additional pay under section 4107(g)(1) of this title in an amount equal to the amount of special pay payable under this section.".

(11) Such section is further amended by adding at the end the following new subsection:

"(i) During fiscal year 1990—

"(1) subsection (b) shall be applied by substituting '$1,000' for '$1,500' in paragraphs (2) and (3); and

"(2) subsections (c)(5) and (c)(6) shall be applied—

"(A) by substituting '$500' for '$1,000' in subparagraph (B);

"(B) by substituting '$2,000' for '$4,000' in subparagraph (C); and

"(C) by substituting '$1,000' for '$1,500' in subparagraphs (D) and (E).".

SEC. 102. PREMIUM PAY FOR LICENSED PRACTICAL OR VOCATIONAL NURSES AND NURSE ASSISTANTS.

(a) IN GENERAL.—Section 4107(e) is amended by adding at the end the following new paragraph:

"(11) For purposes of this subsection, an employee of the Veterans' Health Services and Research Administration who is a licensed practical or vocational nurse or a nurse assistant shall be treated in the same manner as a registered nurse.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on October 1, 1989.

SEC. 103. CLARIFICATION OF CERTAIN LIMITATIONS WITH RESPECT TO EMPLOYMENT.

(a) LIMITATIONS ON OUTSIDE EMPLOYMENT.—Section 4108 is amended by adding at the end the following new subsection:

"(e) Any provision of this title limiting employment outside of the Department by an employee of the Department shall not apply to an employee who is appointed under the provisions of title 5 and paid under the provisions of this title.".

(b) COMPENSATION OF EMPLOYEES WHO ARE RETIRED MILITARY PERSONNEL.—(1) Section 4107(i) is amended by inserting "or registered nurse" after "physician".

(2) The amendment made by paragraph (1) shall take effect on the first day of the first pay period beginning on or after the date of the enactment of this Act.

SEC. 104. APPOINTMENT OF CERTAIN INDIVIDUALS IN HEALTH-CARE POSITIONS.

Section 4106 is amended by adding at the end the following new subsection:

"(h)(1) The Secretary may appoint qualified individuals in the competitive civil service without regard to the provisions of subchapter I of chapter 33 of title 5 (other than sections 3303 and 3328 of such title).

"(2) For purposes of this subsection, qualified individuals are individuals—

"(A) who have a recognized degree or certificate from an accredited institution in a health-care profession or occupation; and

"(B) who were appointed to and have successfully completed a clinical education program affiliated with the Department.

"(3) In using the authority provided by this subsection, the Secretary shall apply the principles of preference for the hiring of veterans and other persons established in subchapter I of chapter 33 of title 5.

"(4) The Secretary may appoint an individual under this section only upon the recommendation of the Chief Medical Director.".

TITLE II—HEALTH PROGRAM AMENDMENTS

SEC. 201. EXTENSION OF EXPIRING PROGRAMS.

(a) RESPITE CARE.—Section 620B(c) is repealed.

(b) STATE HOME GRANT AUTHORITY.—Section 5033(a) is amended by striking out "September 30, 1989" and inserting in lieu thereof "September 30, 1992".

SEC. 202. HOMELESS VETERANS' PROGRAM

Section 9 of the Veterans' Home Loan Program Improvements and Property Rehabilitation Act of 1987 (38 U.S.C. 1820 note; 101 Stat. 1320) is amended—

(1) in subsection (a)(3)(B)(i), by striking out "solely as a shelter" and inserting in lieu thereof "as a shelter or as transitional housing";

(2) by redesignating subsections (c) and (d) as subsections (d) and (e), respectively;

(3) by inserting after subsection (b) the following new subsection:

"(c) VETERANS PARTICIPATING IN COMPENSATED WORK THERAPY PROGRAM.—(1) To assist veterans who are participants in a compensated work therapy program authorized under section 618 of title 38, United States Code, the Secretary of Veterans' Affairs may convey to persons described in paragraph (2) real property and improvements described in subsection (a)(2) for an amount not less than 75 percent of the fair market value of such real property and improvements.

"(2) The Secretary may convey such property to persons who enter into an agreement with the Secretary to employ veterans who are participants in a compensated work therapy program authorized under such section 618.

"(3) The Secretary may include appropriate enforcement provisions in any agreement described in paragraph (2), including provision for reasonable liquidated damages."; and

(4) in subsection (d), as redesignated by paragraph (2), by striking out "subsections (a) and (b)" and inserting in lieu thereof "this section".

SEC. 203. COMPENSATED WORK THERAPY PROGRAM.

(a) AUTHORIZED SOURCES FOR PROVISION OF THERAPEUTIC WORK.—Subsection (b)(1) of section 618 is amended by striking out "contractual arrangements with private industry or other sources outside the Veterans' Administration" and inserting in lieu thereof "a contract or other arrangement with any appropriate source (whether or not an element of the Veterans' Administration or of any other Federal entity)".

(b) USE OF REVOLVING FUND.—Subsection (c)(1) of such section is amended by striking out "carrying out the provisions of" and inserting in lieu thereof "furnishing rehabilitative services authorized in".

TITLE III—HEALTH-CARE MANAGEMENT

SEC. 301. PILOT PROGRAM FOR IMPROVED SYSTEM FOR COLLECTION OF FEES.

(a) PILOT PROGRAM.—The Secretary shall carry out a pilot program for the establishment of an improved system for the administration of fees and other amounts payable to the

United States arising from programs administered by the Veterans Health Services and Research Administration under the provisions of title 38, United States Code. The pilot program shall be carried out in one medical region of the Veterans Health Services and Research Administration. The pilot program shall be carried out during fiscal years 1990 and 1991.

(b) AUTOMATED PROGRAM FOR BILLING AND COLLECTION.—(1) As part of the system established under subsection (a), the Secretary shall provide for the development of an automated program to carry out billing and collection of fees and other amounts. The automated program shall have the capability to process (A) fees charged to third parties and to government and private agencies which have sharing agreements with the Department of Veterans' Affairs, (B) amounts recoverable by the United States under section 629 of title 38, United States Code, and (C) amounts payable as first-party medical copayments authorized in such title.

(2) In developing such automated billing and collection program, the Secretary shall use billing and collection expertise and services of the private sector.

(c) ALLOCATION OF AMOUNTS COLLECTED.—The Secretary shall defray costs of administering the pilot program, including the costs of any contracts under the program, from amounts received by the Secretary through the program. The Secretary shall allocate remaining amounts received through the pilot program as follows:

(1) 25 percent shall be covered into the Treasury as miscellaneous receipts.

(2) 25 percent shall be allocated to funds and accounts of the medical center through which the amounts were collected.

(3) 50 percent shall be allocated to funds and accounts available to the Chief Medical Director.

(d) USE OF AMOUNTS RETAINED.—The Secretary may obligate amounts retained by the Department of Veterans' Affairs and allocated pursuant to paragraph (2) or (3) of subsection (c). The Secretary shall require that such amounts be used—

(1) for pay and other personnel benefits to enhance the recruitment and retention of health-care employees of the Veterans Health Services and Research Administration; or

(2) to supplement the medical equipment accounts of medical centers at which such accounts are deficient.

(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated the sum of $500,000 to carry out the pilot program under this section.

SEC. 302. ELIGIBILITY OF MILITARY DEPENDENTS FOR HEALTH CARE UNDER SHARING AGREEMENTS.

Section 5011(g)(5) is amended by inserting after "title 10" the following: "or a dependent (as defined in section 1072(2) of such title) who is eligible for care under section 1076 of such title".

SEC. 303. CHAMPVA PROGRAM.

(a) LIST OF BENEFICIARIES.—The Secretary shall compile an accurate and complete list of individuals eligible as of October 1, 1989, for benefits under section 613 of title 38, United States Code. Such list shall be compiled not later than October 1, 1989, and shall be maintained and periodically updated thereafter. The Secretary may pay benefits under that section only to persons whose names are included on the list.

(b) PROGRAM REVIEW.—Not later than October 1, 1989, the Secretary shall establish a procedure for the periodic review of the need for, the cost effectiveness of, and the appropriateness of the provision of health care by the Secretary under section 613 of such title.

(c) INSPECTOR GENERAL REVIEW.—Not later than December 1, 1989, the Inspector General of the Department of Veterans Affairs shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the compliance of the Secretary with subsections (a) and (b). If the report indicates that the Secretary is not in compliance with either such subsection, the Secretary shall promptly submit to those committees a report explaining the reason for any such noncompliance and the plans of the Secretary to correct the deficiency.

(d) STUDY OF ALTERNATIVES.—(1) The Secretary shall carry out a study of alternative methods for providing for the costs of health care which are currently provided under section 613 of such title. In carrying out the study, the Secretary shall consider methods which would result in a substantially unchanged cost to the United States while providing improved health benefits at lower costs to beneficiaries.

(2) The Secretary shall submit a report on the results of the study to Congress not later than one year after the date of the enactment of this Act.

(3) There is authorized to be appropriated the sum of $500,000 to carry out the study under this subsection.

SEC. 304. CANTEEN SERVICE.

(a) LIMITATION ON EMPLOYMENT.—Section 4203 is amended by adding at the end the following new subsection:

"(c) A contract or other agreement may not be made by or on behalf of the Service for performance by an individual not directly employed by the United States of any activity otherwise performed by an individual employed by the United States who is compensated with nonappropriated funds.".

(b) INDEPENDENT STATUS WITHIN THE DEPARTMENT OF VETERANS' AFFAIRS.—Section 4208 is amended—

(1) by striking out "It is the purpose of this chapter that, under" and inserting in lieu thereof "Under the"; and

(2) by adding at the end the following: "The head of the Service may not be required to report to or be supervised by any official of the Department other than the Secretary and Deputy Secretary.".

I

101ST CONGRESS
1ST SESSION

H. R. 1199

To amend title 38, United States Code, to improve recruitment and retention of nurses in the Department of Veterans' Affairs by providing greater flexibility in the pay system for those nurses.

IN THE HOUSE OF REPRESENTATIVES

MARCH 1, 1989

Mr. KENNEDY (for himself, Mr. RIDGE, Mr. STAGGERS, Mr. BRENNAN, Mr. ROWLAND of Connecticut, Mr. ROBINSON, Mr. FLORIO, and Mr. EVANS) introduced the following bill; which was referred to the Committee on Veterans' Affairs

---

A BILL

To amend title 38, United States Code, to improve recruitment and retention of nurses in the Department of Veterans' Affairs by providing greater flexibility in the pay system for those nurses.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Veterans Nurse Pay Act of 1989".

SEC. 2. RESTRUCTURING OF NURSE GRADE LEVELS.

(a) NEW GRADES ESTABLISHED.—The Secretary of Veterans Affairs shall restructure the current nurse grades of the Department of Veterans Affairs so as to provide four grade levels for nurses employed by that Department under section 4104(1) of title 38, United States Code. Those grade levels shall be established with the following relationships to the current nurse grades and to pay grades under the General Schedule under title 5, United States Code.

New Grades	Current Grades	GS Grades
1. Entry grade	Junior & associate grades	GS 6-10
2. Intermediate grade	Full & intermediate grades	GS 9-12
3. Senior grade	Senior & chief grades	GS 12-14
4. Director grade	Assistant director & director grades	GS 14-16

(b) CURRENT NURSE GRADES DEFINED.—For purposes of subsection (a), the term "current nurse grades' means the grades in effect on the effective date of this Act for nurses employed by the Department of Veterans Affairs under section 4104(1) of title 38, United States Code.

SEC. 3. PAY STRUCTURE AND ADMINISTRATION FOR NEW NURSE GRADES.

(a) IN GENERAL.—Subchapter I of chapter 73 of title 38, United States Code, is amended by inserting after section 4107 the following new section:

"§ 4107A. Nurses: grades, rates of pay, and administration of pay

"(a) The Secretary shall maintain four grade levels for nurses employed by the Department under section 4104(1) of this title. Those grade levels shall have with the following relationships to pay grades under the General Schedule under title 5.

"Nurse Grades	GS Grades
Entry grade	GS 6-10
Intermediate grade	GS 9-12
Senior grade	GS 12-14
Director grade	GS 14-16

"(b) The rates of basic pay for those nurse grades shall, for each grade, be a range of pay established by law or by Executive order under chapter 53 of title 5, United States Code. Until such a law or Executive order takes effect after the date of the enactment of this section, the minimum and maximum rates of basic pay in effect for each nurse grade shall be the lowest minimum and the highest maximum, respectively, for the GS grades corresponding to the nurse grades.

"(c)(1) The range of basic pay for each nurse grade shall be divided into 20 equal increments, known as 'steps'. Rates of pay within a grade shall be established only as full steps. The rate of basic pay of nurses within a grade shall be increased by such step increases under standards prescribed by the Secretary.

"(2) Regulations prescribed under this section shall provide—

"(A) that the rate of basic pay of each nurse of the Department employed under section 4104(1) of this title shall be increased at least one step increment in that nurse's grade not less often than every two years that the nurse holds that grade (unless the Secretary determines that the performance of the nurse during the preceding two years has not been satisfactory); and

"(B) that whenever a nurse is given a new duty assignment which is a promotion, the rate of basic pay of that nurse shall be increased at least one step increment in that nurse's grade.

"(3) A nurse of the Department serving in a head nurse position shall while so serving receive basic pay at a rate two steps above the rate that would otherwise be applicable to the nurse.

"(d) A nurse who is promoted to the next higher nurse grade shall be appointed in that grade at a rate of basic pay that is greater than the rate of basic pay applicable to the nurse in the lower grade.

"(e) Under regulations which the Secretary prescribes for the administration of this section, the director of a medical center of the Department may provide step promotions within a grade, or may pay a cash bonus, to a nurse employed at the medical center who has qualifications, experience, or achievement which the director determines exceed the standards for the nurse's grade. In making such a determination, the director shall consider the following:

"(1) Service with relevant professional committees or groups.

"(2) Service in a responsible office in a professional nursing society.

"(3) Educational attainment (including certification).

"(4) Publication of articles in professional journals.

"(5) Exemplary job performance.

"(6) Other appropriate evidence of professional stature.

"(f)(1) The Secretary shall provide (in regulations prescribed for the administration of this section) that the director of a medical center of the Department, in appointing a person under section 4104(1) of this title as a nurse for employment at that medical center, may appoint that nurse at a rate of basic pay in excess of the minimum rate of basic pay applicable to the grade in which the appointment is made (but not in excess of the maximum rate of basic pay for that grade) without a requirement for prior approval at any higher level of authority within the Department if the director determines that it is necessary to do so in order to obtain the services of nurses employed under section 4104(1) of this title in that nurse grade at that medical center.

"(2) Such a determination may be made by the director of a medical center only in order—

"(A) to provide pay in an amount competitive with the amount of the same type of pay paid to nurses at non-Federal facilities in the same labor market;

"(B) to achieve adequate staffing at the medical center concerned; or

"(C) to recruit nurses with specialized skills, especially nurses with skills which are especially difficult or demanding.

"(3) Whenever the director of a medical center exercises authority under this subsection without prior approval at a higher level of authority within the Department, the director shall—

"(A) justify in writing the reasons for employing the nurse concerned at a rate of pay in excess of the minimum rate of basic pay applicable to the grade in which the nurse is appointed (and shall retain that justification on file); and

"(B) in the first budget submission of the director prepared after the nurse is employed, include justification for the need for such increased rates of basic pay.

"(g) A nurse employed under section 4104(1) of this title who (without a break in employment) transfers from one medical center of the Department to another may not be reduced in grade, but may be reduced in step within grade if such a reduction is consistent with the pay structure at the medical center to which the nurse transfers.".

(b) TRANSFERS.—(1) Subsection (e) of section 4107 of such title is transferred to the end of section 4107A, as added by subsection (a), redesignated as subsection (h), and amended—

(A) in paragraph (1), by striking out "the rate of basic pay provided for nurses in subsection (b)(1) of this subsection" and inserting in lieu thereof "basic pay";

(B) in paragraph (5), by striking out ", not to exceed" in the first sentence and all that follows through "Nurse Schedule".

(2) Subsection (h) of section 4107 of such title is transferred to the end of section 4107A, as amended by subsection (b)(1), redesignated as subsection (i), and amended—

(A) in paragraph (2)(B), by striking out "one thousand two hundred and forty-eight" and inserting in lieu thereof "1,248"; and

(B) in paragraph (2)(C)—

(i) by striking out "subsection (e)(5)" both places it appears and inserting in lieu thereof "subsection (h)(5)"; and

(ii) by striking out "subsection (e)" and inserting in lieu thereof "subsection (h)".

(c) CONFORMING AND CLERICAL AMENDMENTS.—(1) Section 4107(b) of such title is amended by striking out the items under the heading "NURSE SCHEDULE" and inserting in lieu thereof the following:

"Entry grade.
"Intermediate grade.
"Senior grade.
"Director grade.".

(2) The table of sections at the beginning of chapter 73 of such title is amended by inserting after the item relating to section 4107 the following new item:

"4107A. Nurses: grades, rates of pay, and administration of pay.".

SEC. 4. EFFECTIVE DATE.

Section 2 and the amendments made by section 3 shall take effect on October 1, 1989.

SUMMARY

H. R. 901, proposed legislation to amend title 38, United States Code, to improve programs for the recruitment and retention of health-care personnel of the Department of Veterans Affairs, to extend certain expiring programs of that department, and for other purposes, would:

(1) Require the Secretary to provide primary special pay of $1,500 per year, in addition to basic salaries, to nurses employed on a full-time basis (or in the case of a nurse employed on a part-time basis, a proportional amount shall be calculated on the basis of the proportion which the part-time employment bears to full-time employment).

(2) Require that the Secretary provide incentive special pay, in addition to primary special pay, of not more than $5,500 per year to any eligible full-time nurse (or in the case of a nurse employed on a part-time basis, a proportional amount shall be calculated on the basis of the proportion which the part-time employment bears to full-time employment) as follows:

(a) For tenure of service of 2 years but less than 5 years, $500;
(b) For tenure of service of 5 or more years, $1,000;
(c) For service in intensive care units, critical care units, emergency or operating rooms, or in a nursing specialty which the Chief Medical Director has determined that there are extraordinary difficulties in recruitment or retention, $4,000;
(d) For service in locations where the Chief Medical Director determines there are extraordinary difficulties in recruitment and retention, $1,500;
(e) For service in a head nurse position, $1,500.

The maximum of primary and incentive special pay for eligible nurses may not exceed $7,000 per year.

(3) Authorize the Secretary to provide nurses, who are eligible for primary and incentive special pay, special salary rates under section 4107(g)(1) of title 38, United States Code, in order to recruit and retain nurses.

(4) Provide, on or after October 1, 1989, that licensed practical or vocational nurses and nursing assistants are eligible for premium pay for Saturday duty on the same basis as registered nurses.

(5) Clarify the limitation on outside employment for Department of Veterans' Affairs health-care personnel employed under the auspices of title 5, United States Code, and paid under the auspices of title 38, United States Code.

(6) Provide that no reductions shall be made from the salaries of Department of Veterans' Affairs nurses eligible for military retirement pay effective on the first day of the first pay period beginning on or after the date of enactment.

(7) Permit health-care personnel hired under the auspices of title 5, United States Code, to be hired without regard to the competitive civil service by the Department of Veterans' Affairs if they have a recognized degree or certificate from an accredited academic institution and have successfully completed a clinical education program affiliated with the Department of Veterans' Affairs.

(8) Make permanent the Department of Veterans' Affairs program for providing respite care to eligible veterans.

(9) Extend the authority to make grants for the State Veterans' Homes program from September 30, 1989 until September 30, 1992.

(10) Authorize discounts on the sale of Department of Veterans' Affairs difficult-to-sell foreclosed properties to nonprofit organizations for use as transitional housing for homeless veterans in addition to use as shelters as is provided in current law.

(11) Allow the Secretary, in order to provide for therapeutic work for veterans under the VA's rehabilitative Compensated Work Therapy program, to contract with Federal agencies rather than being limited to contracting only with private and non-profit entities as is required in current law.

(12) Require the Secretary to establish a 2-year pilot program in one medical region, for fiscal years 1990 and 1991, for an improved, automated management system for billing and collections of fees charged to third parties and for agencies which have sharing agreements with the Department of Veterans' Affairs as well as first-party medical copayments, and authorizes an appropriation of $500,000 for the pilot program.

(13) Provide that amounts received under the 2-year automated pilot program shall be allocated as follows:

(a) 25 percent to the Treasury of the United States;
(b) 25 percent to the VA medical center which collected
  the funds; and,
(c) 50 percent to the Chief Medical Director

Require that the collected fees retained by the Department of Veterans' Affairs shall be used for pay and personnel benefits to enhance the recruitment and retention of health-care employees, and to supplement the medical equipment accounts of medical centers which have deficient equipment accounts.

(14) Authorize dependents of DOD beneficiaries to receive health care in Department of Veterans' Affairs medical facilities, on a space available basis, which have VA/DOD sharing agreements.

(15) Direct the Secretary to compile an accurate and complete list of individuals eligible as of October 1, 1989 for benefits under the Civilian Health and Medical Program of the Department of Veterans' Affairs (CHAMPVA) by October 1, 1989. Require that the Department of Veterans' Affairs Inspector General submit a report to the Committees on Veterans' Affairs of the House and Senate by December 1, 1989 on the Secretary's compliance in compiling the list of eligibles.

(16) Remove the Veterans Canteen Service from the direction and supervision of the Chief Medical Director and prohibit contracting out of services under provisions of OMB Circular A-76.

SUMMARY

Proposed draft legislation to amend title 38, United States Code, to make certain improvements in veterans' health-care programs and for other purposes would:

(1) Rescind the VA medical regulation, which became effective on May 23, 1988, limiting the length of an extension of a contract for care of a veteran with non-service-connected disabilities in a community nursing home.

(2) Require the Geriatrics and Gerontology Advisory Committee to submit to the Secretary, from time to time, such reports as it considers appropriate. Thirty days after receipt of such a report, the Secretary would be required to submit the report to the Congress.

(3) Require that a veteran entitled to a prosthetic appliance be furnished such services for fitting and training in the use of such appliance as may be necessary. Such services shall include institutional training when necessary. Such services may be provided in a Department of Veterans Affairs facility, in a training institution other than a DVA facility or by outpatient treatment. Such services may be provided under contract. A veteran being provided such services may be provided travel and incidental expenses between the veteran's home and the hospital or training institution where such services would be provided.

(4) Require that not later than February 1 of each year, the Secretary submit to the Committees on Veterans Affairs of the House and Senate a report on the delays in the furnishing of prosthetic services which occurred during the preceding fiscal year. Each report should set forth:

a. the number, and location of medical facilities at which orders for such services were held more than 5 days.

b. the number of such orders that were held more than 5 days.

c. the average length of time such orders were held at each such facility.

d. the total dollar amount of orders held more than 5 days.

e. the reasons for the delays in placing such orders.

STATEMENT BY THE
HONORABLE DAN L. BURTON

SUBCOMMITTEE ON HOSPITALS
AND HEALTH CARE

APRIL 12, 1989

GOOD MORNING, MR. CHAIRMAN. AS A RECENTLY APPOINTED MEMBER OF THIS COMMITTEE, I LOOK FORWARD TO WORKING UNDER YOUR LEADERSHIP IN ASSURING THAT QUALITY HEALTH CARE IS AVAILABLE TO OUR VETERANS. AS AMERICA'A VETERANS GROW OLDER, MANY LOOK TO THE DEPARTMENT OF VETERANS AFFAIRS TO PROVIDE THE HEALTH CARE THEY NEED. WE MUST KEEP THE PROMISES THAT WERE MADE TO OUR SERVICEMEN THAT QUALITY CARE IS THEIR RIGHT. WE MUST NOT LET BUDGET RESTRICTIONS ERODE OUR DUTY TO PROVIDE THAT CARE.

THE NURSING SHORTAGE WHICH EXISTS IN THE HEALTH CARE PROFESSION IS DRASTICLY REDUCING THE DVA'S ABILITY TO MAINTAIN ADEQUATE MEDICAL FACILITIES. BACK IN MY DISTRICT IN INDIANA, THE ROUDEBUSH VETERANS MEDICAL CENTER HAD TO CLOSE TWO WARDS BECAUSE OF A SHORTAGE OF QUALIFIED NURSES TO STAFF THEM. THANKFULLY, NO VETERAN HAS BEEN TURNED AWAY FROM THAT MEDICAL CENTER YET, BUT UNLESS WE ACT TO IMPROVE THE NURSING SITUATION AND INCREASE PAY SCALES, ALL THE HOSPITAL BEDS IN THE WORLD WILL BE WORTHLESS WITHOUT NURSES TO CARE FOR PATIENTS IN THEM.

MR. CHAIRMAN, THANK YOU FOR SCHEDULING COMMITTEE TIME TO HEAR TESTIMONY ON THE DVA'S NURSING SITUATION AND EXAMINE OUR OPTIONS TO DEAL WITH IT. YOUR LEADERSHIP ON THIS ISSUE WILL NOT BE FORGOTTEN BY THE VETERANS BACK IN MY DISTRICT WHEN THEY ASK FOR THE HEALTH CARE THAT WAS PROMISED TO THEM.

[illegible]

OPENING REMARKS
HONORABLE CHRIS SMITH, NJ
VETERANS' AFFAIRS SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
HEARING ON HR 901 AND 1199, RECRUITMENT AND RETENTION OF HEALTH CARE PERSONNEL, AND DRAFT LEGISLATION ON PROSTHETIC SERVICES AND COMMUNITY NURSING HOME CARE
APRIL 12, 1989

Thank you Mr. Chairman.

Mr. Chairman, I appreciate your efforts in arranging this hearing to review legislation to improve recruitment and retention of health care professionals in VA hospitals.

I believe it is obvious that changes in the way we deal with nursing shortages in VA hospitals are needed. We need to provide added incentives to attract nurses to the VA and we need to enable VA hospitals to be more responsive to their individual staffing needs.

HR 901 and HR 1199 provide the tools necessary to work toward this goal. HR 901 mandates a pay bonus for VA nurses plus special pay incentives for nurses who agree to work for the VA for extended time periods. The bill also eases restrictions on outside employment for certain VA employees and offers premium pay for nursing assistants and LPNs. These measures, I believe, will make the VA a more attractive employer and improve the VA's ability to recruit nurses.

HR 1199 also takes steps in this direction by enabling individual VA medical centers to monetarily reward their nurses for professional achievements and provide small salary increases without overwhelming administrative burdens.

Additionally, Mr. Chairman, I have been considering adding an incentive to the GI Bill or another educational program that would encourage recruits to enter the nursing or allied health professions. In return for a boost in educational assistance, the recruit would be required to commit a certain period of time to service in a VA hospital. This proposal, I believe, is very timely and very badly needed in light of the current situation facing VA health care facilities.

Mr. Chairman, I strongly support the legislation we are reviewing today, and am confident that our Subcommittee will continue to address the current problems within the VA medical system in order to improve services for our veterans. I'd like to thank our witnesses for appearing here today and look forward to hearing their testimonies.

OPENING STATEMENT
OF
THE HONORABLE BOB McEWEN (R-OHIO)

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
HOUSE COMMITTEE ON VETERANS AFFAIRS
APRIL 12, 1989

Thank you, Mr. Chairman.

It is my great pleasure to join you this morning. As is often the case when this subcommittee meets, we have a lot of ground to cover, and a broad range of topics to discuss. That being the case, my opening comments will be brief.

I think my colleagues on the subcommittee will agree with me when I say that the issues on our plate today are the focus of enormous interest among our veteran constituents. Their interest is perhaps best illustrated by the vast volumes of mail it generates.

That is understandable, of course, as we have responsibility for overseeing every stage of a process which should provide the best available health care to a most deserving and worthy group of Americans.

I don't think it requires a particularly Utopian view of the world to believe the veterans health care system could and should reflect our nation's deep commitment to that system's intended beneficiaries. We can accomplish a great deal -- in the present -- here and now -- with this government -- and we can do it with administrative, scientific and creative resources which America holds in abundance.

Today's hearing enables us to fucus appropriate attention on the need for sound, flexible management and sufficient staffing of veterans health facilities by dedicated health care professionals. As we prepare to consider these and related questions, I want you all to know that I am confident the government has the will, the capability and the responsibility to provide the health care our veterans deserve.

I am certain today's guests are prepared to offer direction on how this might best be achieved. Mr. Chairman, I commend you on assembling an outstanding witness roster with whom to discuss the business of veterans health care. I look forward to hearing their testimony.

STATEMENT OF HARLEY O. STAGGERS, JR.

before
THE HOSPITAL AND HEALTH CARE SUBCOMMITTEE
April 12, 1989

MR. CHAIRMAN, LET ME THANK YOU AND THE MEMBERS OF THE SUBCOMMITTEE FOR ALLOWING ME THE OPPORTUNITY TO APPEAR BEFORE YOU THIS MORNING. IT WAS MY PLEASURE TO SERVE ON THIS SUBCOMMITTEE DURING THE 98TH, 99TH AND 100TH SESSIONS OF CONGRESS.

MR. CHAIRMAN, I AM HERE BECAUSE OUR HOSPITAL SYSYTEM IS SCREAMING. OUR HOSPITALS ARE NOT SCREAMING FOR ATTENTION, THEY ARE SCREAMING OUT IN PAIN FROM THE CUTS THEY HAVE SUFFERED. THEY ARE SUFFERING FROM A LACK OF RESOURCES, LACK OF SUPPLIES, LACK OF ADEQUATELY COMPENSATED HEALTH CARE PROFESSIONALS AND A SYSTEM OF RESOURCE ALLOCATIONS THAT SEEMS TO GIVE LESS RESOURCES TO DO THE JOB EACH YEAR, AT A TIME WHEN THE VA HOSPITAL SYSTEM IS FACING INCREASING DEMANDS, PARTICULARLY BY THE INCREASINGLY OLDER VETERAN POPULATION.

I AM HERE TODAY BECAUSE I SHARE THE FRUSTRATION THIS COMMITTEE HAS FELT OVER THE YEARS AS WE HAVE WORKED TO KEEP OUR HOSPITALS AND HEALTH CARE SYSTEM THE FINEST IN THE WORLD. I AM HERE THIS MORNING TO EXPRESS MY SUPPORT FOR YOUR LEGISLATION H.R. 901 AND H.R. 1199 INTRODUCED BY OUR COLLEAGUE JOE KENNEDY. BOTH MOVE IN A POSITIVE DIRECTION AND WILL, IF PASSED, ASSIST OUR BELEAGUERED HEALTH CARE SYSTEM.

DURING THE PAST YEAR, I HAVE SPENT MANY DAYS TRYING TO COME TO AN APPROACH THAT WOULD HELP OUR HOSPITALS, HELP OUR NURSES AND OTHER PROFESSIONAL EMPLOYEES, AND END A PERVERSE SYSTEM THAT HAS VA PERSONNEL COLLECTING OVER $105 MILLION DURING THE PAST FISCAL YEAR FROM PERSONS WHO USE VA HOSPITALS AND SEND THAT MONEY TO THE TREASURY WITHOUT ANY BENEFIT TO THE VA HEALTH CARE SYSTEM THAT COLLECTED THAT MONEY. MR. CHAIRMAN, AT A TIME WHEN VA HOSPITALS ARE UNABLE TO SERVE VETERANS, IT IS INCONCEIVABLE THAT THE MONIES COLLECTED ARE NOT PLOWED BACK INTO THE HEALTH CARE SYSTEM THAT SO DESPERATELY NEEDS THOSE RESOURCES.

IN ALL MY DISCUSSION WITH VETERANS, NOTHING SEEMS TO ANGER THEM MORE THAN THE DISCOVERY THAT THE MONEY THAT IS PAID DOES NOT DO ANYTHING TO SUPPORT THE HOSPITAL THAT PROVIDED THE SERVICE OR VA HEALTH CARE SYSTEM.

MR. CHAIRMAN, I AM WORKING ON LEGISLATION THAT WOULD DO THREE SIMPLE THINGS:

FIRST, IT WOULD PROVIDE THAT ONE-THIRD OF THE MONIES COLLECTED AS FEES BY THIRD PARTY HEALTH INSURANCE REIMBURSEMENTS BE USED TO SUPPORT OUR HEALTH CARE PROFESSIONALS, PARTICULARLY THE NURSING PROFESSIONALS, WHO SEEM TO HAVE BEEN SO BADLY ABUSED UNDER OUR PRESENT SYSTEM.

SECOND, IT WOULD ALLOW THE HOSPITALS THAT COLLECT THE MONIES TO RETAIN ONE-THIRD OF THE REIMBURSEMENTS.

THE FINAL THIRD WOULD GO TO THE DEFICIT REDUCTION IF THE CONGRESS HAS NOT PASSED A SUPPLEMENTAL APPROPRIATION DURING THE LAST FISCAL YEAR. IF WE PASS A SUPPLEMENTAL DURING THE A PREVIOUS SESSION, THEN MY LEGISLATION WOULD REQUIRE THE FINAL PORTION TO GO TO SUPPORT THE GENERAL OPERATION OF DEPARTMENT OF MEDICAL SERVICES

MY INTENTION IS TO SIGNIFICANTLY IMPROVE THE FUNDING NEEDED TO ATTRACT AND RETAIN THE NURSING PROFESSIONALS OUR SYSTEM NEEDS. IT ALLOWS THE CENTER, THAT COMMITS SIGNIFICANT PERSONNEL RESOURCES TO BILL AND COLLECT REIMBURSEMENTS, TO RETAIN A PERCENTAGE OF MONIES COLLECTED. IN ADDITION, IT LETS THE VETERAN USING THE LOCAL VA MEDICAL CENTER KNOW THAT HIS REIMBURSEMENT IS HELPING THE LOCAL HOSPITAL OPERATE. IT DOES NOT APPEAR THAT THE WE SHOULD IN NAME BE SENDING MONEY TO THE TREASURY FOR DEFICIT REDUCTION IN THE FORM OF SLIGHTLY OVER $100 MILLION WHEN THIS COMMITTEE IS ASKING FOR A SUPPLEMENTAL OF MORE THAN $400 MILLION. THE ADDITIONAL MONEY IS NEEDED AND, AS LONG AS WE DO NOT ADEQUATELY FUND THE VA, THAT MONEY SHOULD BE COMMITTED TO THE DEPARTMENT OF MEDICINE AND SURGERY (DMS).

MY IDEAS ARE NOT PERFECT, NO LEGISLATIVE IDEA IS; HOWEVER, THIS APPROACH IS AN IDEA WHOSE TIME HAS COME. I LOOK FORWARD TO YOUR SUGGESTIONS ON WAYS TO IMPROVE THIS IDEA.

I LOOK FORWARD TO WORKING WITH YOU ON THE PROPOSALS BEING REVIEWED TODAY, AS WELL AS MY SUGGESTIONS ON WAYS TO IMPROVE OUR HEALTH CARE SYSTEM. IT IS AN OBLIGATION THAT THIS CONGRESS OWES TO OUR VETERANS TO MAKE EVERY EFFORT TO IMPROVE THAT SYSTEM.

CONGRESSMAN LEWIS F. PAYNE, JR.
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
April 12, 1989

MR. CHAIRMAN, thank you very much for your continued leadership to improve services provided to the veterans of this nation.

One of the most frequent complaints that I hear from my constitutents regarding veterans hospitals is the lack of nurses. All hospitals face serious nursing shortages, and the VA is no exception. HR 901 will make the VA more competitive with other health care facilities, and hopefully attract more nurses, and other health care professionals, to the VA.

In addition to providing incentives for nurses to work for the VA, HR 901 has several other meritorious features, some of which are cost saving measures. All of the proposals, however, are designed to improve the health care programs available to veterans through the Department of Veterans Affairs.

I am an original co-sponsor of HR 901 and feel strongly that the corrections and new programs in this bill will provide for better care for our veterans. We, as a nation, made a solemn pledge to those who have fought for our country, and it is our duty to ensure that our veterans receive the best possible health care.

FRANK McCLOSKEY
8TH DISTRICT, INDIANA

ARMED SERVICES COMMITTEE
PROCUREMENT AND
MILITARY NUCLEAR SYSTEMS
INVESTIGATIONS
DEFENSE POLICY PANEL

POST OFFICE AND CIVIL SERVICE
COMMITTEE
CHAIRMAN, POSTAL PERSONNEL
AND MODERNIZATION
CIVIL SERVICE

FOREIGN AFFAIRS COMMITTEE
AFRICA
TASK FORCE ON
INTERNATIONAL NARCOTICS CONTROL

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April 21, 1989

Honorable G.V. (Sonny) Montgomery
Chairman
House Committee on Veterans' Affairs
Subcommittee on Hospitals
and Health Care
338 Cannon House Office Building
Washington, D.C. 20515

Dear Chairman Montgomery:

Enclosed you will find a statement for the April 12 hearing record from Mr. Terrence Johnson, Director of the Veterans' Administration Medical Center in Indianapolis, Indiana.

As you will recall, you indicated that the agenda of the April 12 hearing was legislative in scope, but Mr. Johnson was welcome to submit his statement regarding the shortage of nurses facing his facility.

I am pleased to submit this statement on Mr. Johnson's behalf and thank you for the opportunity to present his views. Please contact me if you have any questions.

Sincerely,

Frank McCloskey

Frank McCloskey
Member of Congress

FM:bal
Enclosure: 2 pages

Richard L. Roudebush Medical Center 1481 W. 10th Street
Indianapolis, IN 46202

Veterans Administration

APR 20 1989

In Reply Refer To: 583/00

Honorable Frank McCloskey
Member of Congress
127 Cannon Building
Washington, DC 20515

SUBJ: Medical Center Concerns over the Nursing Shortage

Thank you for the recent invitation to submit a written statement for inclusion in the Senate hearing letter. We appreciate this opportunity to focus upon the nursing shortage and its impact on the care of our veterans.

1. **Budgetary Implications**

During the September 1988 Senate Veterans Affairs Committee, I explained the impact of the budget shortage in all areas of our Medical Center. Lack of funding has affected our ability to purchase equipment, limited the categories of patients we can treat and limited our ability to offer the community standard salaries to many professional groups. This is especially true for registered nurses.

We have had to take 98 beds out of service. This action was prompted by the nursing shortage as well as the budget shortage and phasing requirements of a major construction project. Despite this reduction and consolidation of inpatient beds, we have been forced to expend about $30,000 per month in overtime and about $30,000 per month in agency nursing support to maintain an acceptable safe level of care.

2. **Efforts Expended**

Our on-duty registered nurse level has been declining for the past three years. We are currently recruiting to fill 36 registered nurse vacancies, and our cumulative nursing staffing level is 25 positions below last year's level. Approximately 30 additional nursing personnel and related funding will be required to activate our newly constructed surgical intensive care unit.

Our overall ability to retain nurses is declining in spite our extensive recruitment efforts. The nursing turnover rate has increased to 28%, up from 17% in the prior year. This increase in turnover is attributed primarily to retirements of more senior nurses and job changes by nurses with a tenure in the VA of less than three years to pursue better salaries and benefits in the community hospitals.

"America is #1—Thanks to our Veterans"

Recruitment of nurses has become expensive and time consuming. We have significantly increased our advertising and recruitment efforts. Considerable attention has been given to the use of incentives like life style work schedules, tuition reimbursement and bonuses to employees who successfully recruit a registered nurse. Once recruited, many nurses must undergo a three month orientation and training program to become fully productive in this tertiary level medical center.

3. Competition for Nurses

The demand in central Indiana for nurses exceeds the supply, particularly for the bedside nurse. The community hospitals are very competitive in their recruitment and retention efforts. Over the last 14 months special salary rates for registered nurse have been adjusted upward four times, but even this lags about six months behind the salary and benefits of the community hospitals due to the VA's special rate processing time.

The VA is frequently not the employer of first choice to prospective nurses for factors other than salary and benefits. Many times a key consideration for prospective nurses is the nurse to patient ratio. The number of patients per nurse is considerably higher at this medical center than at a comparable community hospital. Another consideration is the number of ancillary personnel available to support the bedside nurse. Due to low medical center-wide staffing levels, we normally have fewer employees to perform ward secretarial duties, patient transportation, housekeeping, and similar ancillary ward support personnel than community hospitals.

Salary, workload benefits, flexibility, lack of equipment, inability to provide adequate support services, and the ability of the private sector to offer the same or better salary and benefit packages have all negatively impacted our ability to recruit needed nursing staff.

4. Optimistic for the Future

We would like to see the Indianapolis Nursing Service continue to be a leader in the nursing profession, professional organizations, in nursing research, and in the eduction of new nurses. We feel that despite this high pressure environment, our Medical Center continues to provide quality and compassionate service to our veterans.

Your continued interest in these concerns that impact on Indiana veterans is appreciated. If there is any other additional information or assistance needed, please do not hesitate to call.

Terence Johnson
TERRENCE L. JOHNSON
Medical Center Director

STATEMENT OF
JOHN A. GRONVALL
CHIEF MEDICAL DIRECTOR
BEFORE THE
SUBCOMMITTEE ON HOSPITALS
AND HEALTH CARE
HOUSE VETERANS AFFAIRS COMMITTEE
APRIL 12, 1989

Mr. Chairman and Members of the Subcommittee:

I am pleased to appear before you today to testify on H.R. 901, H.R. 1199, and other VA health care legislation pending before the Committee. These important proposals are designed to improve the VA health-care system, and to extend certain expiring authorities. We are particularly pleased for the opportunity to address provisions intended to assist VA in recruiting and retaining registered nurses and other critical health-care personnel.

H.R. 901

Mr. Chairman, we generally share the aims of H.R. 901, and we favor the enactment of a number of its provisions. We do suggest a number of modifications which we believe will strengthen the proposals, and urge that you reconsider a few of the provisions in light of our comments.

NURSE SPECIAL PAY

The first provision in H.R. 901 would provide special pay to Veterans Health Services and Research Administration (VHS&RA) registered nurses similar to that paid to VHS&RA physicians and dentists. Significant problems exist with respect to the recruitment and retention of registered nurses to work in many of our facilities, and existing incentives may not be completely adequate to solve these problems. Our recruitment and retention difficulties are not universal, however. In some locations, we have little difficulty recruiting nursing staff, and in a few instances, we may be one of the better paying employers. For that reason, we cannot support this broad based and expensive special pay proposal which would increase the pay of all registered nurses regardless of need for such increased pay.

The special pay provision would amend 38 U.S.C. § 4118 to authorize special pay for registered nurses in addition to physicians and dentists. It would add a new clause (C) to subsection (a)(1) providing special pay up to $7,000 per annum, amend subsection (b) to guarantee a minimum of $1,500 for primary special pay, and add new paragraphs (5) and (6) to subsection (c) providing a maximum of $5,500 for incentive special pay. In addition, with respect to incentive special pay, it would authorize maximums of $1,000 for longevity,

$4,000 for certain specialties, $1,500 for service as a head nurse, and $1,500 for certain geographic areas.

Our staffing problems with registered nurses include both urban and rural communities in all regions of the country. We are now exercising a variety of statutory authorities to try and solve these problems, and those authorities, in many cases, are sufficient. Thus, in approximately 125 facilities, we are using discretionary authority to establish special pay rates under section 4107(g). We are also exercising authority under section 4107(e)(10) to raise premium pay rates where necessary to meet competition from community hospitals. Finally, Public Law 100-322 provided authority for us to expand premium pay for Saturday work, and provided for discretionary recruitment and retention bonuses, although the bonus authority has not been implemented since it was unfunded. Nonetheless, despite the enactment of these authorities, we continue to have problems in many locations.

Given the fact that there is an overall shortage of hospital registered nurses, these existing pay authorities, if all were funded, still might not enable us to be competitive with community hospitals in all locations. In view of that, we recently established a Nurse Pay Task Force which is developing a long range proposal for revision of the title 38 nurse pay system. The group is also developing several proposals to serve as interim measures until a pay system revision can be more fully assessed. We recommend that those proposals be allowed to develop through the normal legislative process. We strongly oppose enactment of the special pay proposal contained in H.R. 901, which we do not believe is targeted sufficiently toward solving VA's specific problems. The proposals would result in a very costly program which would in all likelihood have to be funded at the expense of other activities, that would not solve the nurse recruitment and retention problems we have.

Allowing an offset for current special rate costs, and payment of maximum amounts of special pay authorized by the bill, we estimate that this pay proposal would result in additional costs of $17.9 million in Fiscal Year 1990, and $293.3 million over five fiscal years. Because these additional costs are unfunded, the additional pay called for by this proposal necessarily would have to come from existing salary funds.

EXPANSION OF MANDATORY PREMIUM PAY

Section 102 of H.R. 901 would mandate the payment of Saturday premium pay to licensed practical nurses and nursing assistants. We believe the mandatory authority is unnecessary. We now have discretionary authority to pay LPN's (and other title 38 "hybrid" appointees) the same premium pay now authorized for registered nurses when necessary, as determined by the

Secretary, for recruitment or retention. Moreover, because we have no system-wide recruitment and retention problem with these employees, extending mandatory Saturday premium pay to all LPN's and nursing assistants, as this bill would do, is unnecessary. Furthermore, by guaranteeing all forms of premium pay for all nursing personnel, including nursing assistants and similar personnel, this proposal reduces the resources available for skilled nursing personnel for whom recruitment and retention are ongoing challenges. We estimate the cost of this section in FY 1990 to be approximately $9.6 million, and that five-year costs would be approximately $48.0 million.

EMPLOYEE OUTSIDE EMPLOYMENT LIMITATIONS

Section 103(a) would amend 38 U.S.C. § 4108 to clarify that provisions in that section prohibiting remunerated outside clinical employment do not apply to employees appointed under title 5 and paid under title 38. In fact, VA has no employees appointed under title 5 and paid under title 38. We believe this section was intended for employees in the so-called "hybrid" professions (clinical or counseling psychologists, respiratory therapists, licensed physical therapists, licensed practical or vocational nurses, pharmacists, and occupational therapists) individuals who the Secretary may appoint under 38 U.S.C. § 4104(3) pursuant to the provisions of 38 U.S.C. § 4106(g). The outside employment prohibitions imposed by section 4108 do not now apply to the persons in those "hybrid" positions. They apply only to those health-care professionals listed in section 4108, physicians, dentists, podiatrists, optometrists, nurses, physician assistants, and expanded-function dental auxiliaries. Thus, this section is unnecessary. We are willing, however, to clarify this matter through administrative means. There are no costs or savings associated with this provision.

MILITARY RETIRED PAY REDUCTIONS

Section 103(b) would expand our existing authority to grant exceptions to a required reduction in retired military pay for registered nurses.

Section 5532 of title 5, United States Code, now imposes upon retired officers of the uniformed services, a substantial reduction in their retired pay when appointed to civilian positions in the Federal Government. Under that section, the former officer's retired pay, following appointment, is reduced to an amount equal to $7,698.51 plus half the remainder of his retired pay. (Originally the base figure was $2,000; the statute authorizes an increase proportionate to Consumer Price Index increases.) The statute also imposes an overall effective ceiling equivalent to Executive Level V ($75,500) of the combined retired pay and civilian pay.

Naturally, this reduction makes VA employment less attractive for retired military health care officers. We now have authority in 38 U.S.C. § 4107(i) to authorize exceptions to the statutory loss of pay for well-qualified physicians. Exercised infrequently and, we believe, prudently, the authority has nevertheless been particularly helpful in selectively recruiting highly qualified physicians in a variety of scarce categories. In our view, expansion of the authority to include retired military nurses would result in many more of these nurses seeking VA employment when they retire from the uniformed services. This expansion would be particularly helpful in recruiting and retaining nurses at facilities experiencing nursing shortages. Additionally, we recommend that the bill expand the section 4107(i) waiver authority to include not just registered nurses, but all occupations providing patient care services or services incident to direct patient care. This will improve recruitment of retiring military pharmacists, physician assistants, dieticians, therapists, and other shortage category personnel who now avoid Federal civilian employment.

The Administration urges that equivalent authority be provided for the Secretary of Defense. To provide the Secretary of Veterans Affairs authority to grant exceptions to the restrictions in section 5532 of title 5, United States Code, while failing to provide reciprocal authority to the Secretary of Defense, will further exacerbate DOD's difficulties in attracting and retaining health care professionals.

APPOINTMENT OF GRADUATES OF AFFILIATED PROGRAMS

Section 104 would amend 38 U.S.C. § 4106 to authorize VA to appoint graduates of affiliated allied health-care education programs to competitive civil service positions without regard to competitive civil service procedures. We support this provision with two modifications. Under our statutory health-care education mission, we operate clinical education programs in our facilities which annually train approximately 50,000 students in allied health-care occupations, including psychology, social work, audiology, speech therapy, dietetics and recreational therapy. Yet, the complicated and often lengthy civil service process discourages many highly-qualified allied health-care graduates of VA-affiliated clinical education programs from taking jobs with the VA. By the time these graduates complete the process for placement on a civil service register, and are certified to the VA, other health care employers have often already hired them. As a result, we lose potential employees who are already VA-trained. We are currently experiencing staff shortages in some of these positions. This proposal would enable us, without jeopardizing merit principles, to directly hire graduates of proven competence, who already are familiar with our methods, without regard to the competitive service certification process.

The first modification we would recommend is to establish standard minimum qualifications for each occupation to be used when the competitive hiring procedures are waived. This will allow VA to hire quickly, while at the same time preserving the integrity of the merit system. Such minimum qualifications could be established by VA regulation. Without such a qualifications standard, we cannot support the measure.

We suggest one other relatively minor modification in the measure. The proposed section 4106(h)(4) would authorize the Secretary to make appointments of these graduates only upon recommendation of the Chief Medical Director. It is our view that this limitation will delay the appointment process much the same as under civil service procedures. We recommend that the provision provide the Secretary with discretion to delegate appointment authority to an appropriate level.

There are no significant costs or savings associated with this proposal. However, our ability to hire these highly-qualified graduates would reduce administrative costs associated with the recruitment, orientation and training of new employees. We favor its enactment with the above changes.

RESPITE CARE PROGRAM EXTENSION

Section 201(a) would amend 38 U.S.C. § 620B to provide ongoing authority for our respite care program, authority which now expires on September 30, 1989. This extension of authority is similar to an Administration proposal transmitted to the

Congress on March 20, 1989. Respite care services allow us to provide chronically ill veterans who reside at home with brief, planned periods of care in VA facilities in order to provide members of the veterans' families with some relief from the physical and emotional rigors of continuous home care. We have begun to gain experience with the respite care program which allows veterans to remain at home in the care of their loved ones, rather than requiring them to be institutionalized for protracted periods. Thus far, the program appears to be working very well as an effective mechanism for avoiding institutional care. There is no significant cost to the program. We support this proposal for ongoing authority for this successful program.

STATE HOME GRANT PROGRAM EXTENSION

Section 201(b) would authorize appropriations for the State home grant program for three years, through September 30, 1992. The State home grant program provides grant support to States to assist in the construction or acquisition of State home facilities for veterans. Over the years, these grants have created a network of 54 State veterans facilities in 36 States. These facilities make it possible to provide medical care to many more veterans than can receive care in VA facilities. It is a cost-effective program in which Federal participation is limited to no more than 65 percent of the cost of any one project. Extension of this grant program would result in estimated costs of $42 million for Fiscal Year 1990, and $126 million for the three years the program would be extended. VA supports this program, but recommends that it be extended for five years rather than three years as the bill would do.

HOUSING FOR COMPENSATED WORK THERAPY PROGRAM PARTICIPANTS

Section 202 would amend section 9 of the Veterans' Home Loan Program Improvements Act of 1987, Public Law 100-198 (38 U.S.C. § 1820 note) to authorize the Secretary to convey, at a discount, real property obtained as a result of defaults on loans made or guaranteed by the VA, to persons who contract with us to employ veterans as part of the compensated work therapy (CWT) program. Public Law 100-198 authorized the Department to convey this type of property, under certain conditions, to nonprofit organizations and State and local Governments, to assist them in providing housing for homeless veterans and their families. Section 202 would extend that authority to permit similar sales to for-profit and non-profit entities which contract with us to provide CWT activities for our patients.

Pursuant to 38 U.S.C. § 618(b)(1), enacted in 1976, VA operates CWT programs in medical centers throughout the nation. It is a proven cost-effective method of rehabilitation. Under this program VA specialists develop arrangements through which VA contracts with businesses in the community to permit patients, as part of their medical rehabilitation, to perform work for the businesses. This work may take the form of either goods produced or services provided. Work is usually performed at the medical center, but may take place in another work setting. Businesses pay VA for the work performed under the contract, and those funds are deposited in the Special Therapeutics and Rehabilitation Activities Fund (STRAF), a revolving fund, authorized by 38 U.S.C. § 618(c). That fund receives no appropriations. Using funds in the STRAF, we pay patients for their work at rates consistent with the Fair Labor Standards Act. 29 U.S.C. § 201 et seq.

Although we do not have specific data, it is possible that some VA patients who participate in CWT programs are outpatients who are at risk of being homeless. Providing these patients with some form of transitional housing or residential program while they participate in the CWT program could be very beneficial to them. It would appear that the intent of section 202 is to assist contractors participating in CWT activities to obtain housing which they might then use to provide some form of transitional housing for CWT patients. We question whether entities which contract with us to provide work opportunities for CWT patients are necessarily the most appropriate organizations to provide this type of housing, or whether they would even be interested in undertaking such an endeavor. For the most part, those contractors are independent businesses which contract with our CWT programs primarily for the benefit of obtaining work from patients. We have seen no indication that these businesses are interested in providing transitional housing for CWT patients.

EXPANSION OF COMPENSATED WORK THERAPY PROGRAM

Section 203 would amend 38 U.S.C. § 618(b)(1) to broaden our authority to obtain therapeutic work for patients participating in CWT programs. Under current law, we may contract with non-Federal entities (primarily private profitmaking businesses) to obtain therapeutic work projects for CWT participants. Section 203 would expand that authority and permit similar arrangements with VA facilities and Federal entities to provide therapeutic work for patients in the program.

As we discussed above, such arrangements generally involve VA entering into contracts with businesses in the community to permit patients, as part of their medical rehabilitation, to perform work for the businesses. This work may take the form of either goods produced or services provided. Opportunities for therapeutic work for patients also exist in our own facilities and other Federal entities, but existing authority now limits CWT contractual arrangements to sources "outside the Veterans Administration." 38 U.S.C. § 618(b)(1). This proposal would amend section 618 to permit arrangements, contractual or otherwise, with any appropriate source of work including VA facilities and other Federal entities.

Enactment would permit new opportunities for growth in this valuable rehabilitation program. We favor this proposal which, if enacted, would result in no new costs to the VA.

AUTOMATED FEE COLLECTION SYSTEM

Section 301 would direct that we conduct a pilot program to test an automated system for billing and collection of fees payable to the Government in connection with several programs administered by the Veterans Health Services and Research Administration (VHS&RA). It would require that we conduct the two-year pilot program in one of our medical regions. The test program would apply to fees charged to third parties, amounts due to us under sharing agreements, amounts we may recover from insurance companies or other third party payors for care furnished to veterans, and copayments veterans agree to pay to receive VA care. The provision would also direct where we must allocate the funds collected, and the uses the funds may be put to. Under the measure, we would have to allocate twenty-five percent of the funds into the Treasury as miscellaneous receipts, twenty-five percent to the medical center which collected the funds, and fifty percent to accounts available to the Chief Medical Director. The provision would require that we use all funds retained by the Department either for benefits to enhance recruitment and retention of health care employees, or to supplement medical equipment accounts in medical centers where such funds are deficient. We cannot fully support enactment of this provision as drafted.

We are concerned with the funds allocation scheme that section 301 would impose. Under current law, the fees and charges in question are all covered over to the Treasury as miscellaneous receipts. This proposal would direct that VA retain the majority of funds collected. The purpose of the proposed change appears to be to encourage our medical centers to improve billing and collection efforts by providing that the centers and the VA would be able to retain some of the funds collected.

The funds in question are now considered proprietary receipts for budgetary purposes. Under the bill, if medical centers and the Veterans Health Services and Research Administration retain some of the funds collected, the budget process would have to take that into consideration. The total funding available to the Department would not increase as the amounts collected and retained would most likely be considered as offsets against our budget request. The same is true of the proposal's direction that retained funds be used to enhance recruitment and retention, and medical equipment accounts. Those two functions are best provided for in the normal budget process. If there is a need for funds for those purposes, centers may seek those funds in budget requests. Allowing some medical centers additional funds for those purposes because they collected monies from certain billings would only complicate the budget process, with no assurance that those centers would receive any more funds than they would have otherwise received.

Although we cannot support section 301 as drafted, we are currently pursuing greater use of automation in billings and collections and are considering other ways to improve these areas. We would support changes in this program that would permit the use of collections to offset the cost of contracting for collection services, or other similar approaches.

HEALTH CARE FOR DOD DEPENDENTS

Section 302 would authorize us to provide health care to DoD dependents at VA facilities under VA/DoD sharing agreements. Current law prohibits the provision of such care in our facilities under VA/DoD sharing agreements. 38 U.S.C. § 5011(d)(1). We are interested in exploring avenues for sharing between VA and DOD. We are unable, at this time, however, to support the concept of VA caring for DOD beneficiaries. Such an arrangement raises numerous unresolved issues that could have a significant impact on the VA medical care system.

CHAMPVA

Section 303 would require that we compile and maintain a complete and accurate list of CHAMPVA eligibles by October 1, 1989, and establish procedures for periodic review of the cost-effectiveness and appropriateness of health care provided. It also would charge the Inspector General to report to the Committees on Veterans' Affairs regarding our compliance with these measures, and require the Secretary to report on and correct any deficiencies. Finally, it would require us to study alternative methods for providing the cost of health care to CHAMPVA beneficiaries, and report on those alternatives within a year of enactment of this statute. The provision would authorize the appropriation of $500,000 to carry out this study.

In view of the efforts underway to improve the administration of the CHAMPVA program, enactment of this proposal is unnecessary and we do not favor it. The primary actions contemplated by the bill are already in place or well underway. We now have new computer software to assist in processing applications for CHAMPVA benefits and to provide ongoing monitoring of beneficiary eligibility. The system is capable of producing a list of individuals eligible for CHAMPVA benefits, negating the need for statutory direction that such a list be developed. Moreover, in accordance with a subcommittee request made at a CHAMPVA oversight hearing held in March 1988, we now provide quarterly reports as to the costs and effectiveness of the CHAMPVA health care program.

CANTEEN SERVICE PROVISIONS

Section 304(a) would amend the Veterans Canteen Service statute to prohibit the Service from contracting out performance of any activity otherwise performed by a Federal employee compensated from non-appropriated funds.

We oppose section 304(a). It would deprive the Secretary of the flexibility necessary to operate the Service -- either with VCS employees or by utilizing contractors -- according to its needs. At individual canteens, VCS now contracts for an array of services -- ranging from vending machine to cleaning services -- which could be performed by VCS employees. Contracting decisions reflect the VCS' need for the service, its efficiency, its costs, and the availability of personnel to perform it. Generally, prohibiting VCS from contracting for services which may be performed by VCS employees could be construed to bar renewal of VCS' many existing contracts. Thus, it would eliminate any efficiencies or economies gained from existing contracts and adversely affect VCS' financial structure which reflects those economies. Applying section 304(a) only to an individual canteen, rather than to the Service as a whole, would freeze that canteen's operation, depriving the Secretary of the flexibility to adjust its operations, as to vending machine services, for example, to meet changes in the medical center or veterans' population which the canteen serves.

Section 304(b) would prohibit the head of the Canteen Service from being required to report to any VA official other than the Secretary or Deputy Secretary of Veterans Affairs. We strongly oppose section 304(b). First, this provision would require the Secretary or Deputy Secretary to exercise direct line authority over the Service, which has operations at over 170 VA medical facilities. Day-to-day administration over VCS raises operational and policy issues concerning, among other things, pricing, supply and procurement and personnel management. Title 38 does not require the Secretary and his deputy to exercise such authority over any other element of the Department. Such a role does not seem consistent with that of a Cabinet officer or his deputy. Rather, Congress in its wisdom has generally left these officials discretion as to the means through which they exercise their statutory responsibilities.

We urge against a departure from this salutary policy. It is noteworthy that Canteen Service, in its infancy, was organized within the Office of the Administrator of Veterans Affairs. The importance of having a close link between Canteen Service and the VA medical program was highlighted in recommendations made by Booz, Allen, Hamilton which led to a 1955 reorganization. Under that realignment, VCS has successfully carried out its mission over the years, and we are aware of no subsequent management or organizational study calling into question the early judgment that the Chief Medical Director should exercise the powers and functions of the Secretary with respect to the maintenance and operation of the Canteen Service.

Moreover, the enactment of this subsection would not necessarily change the substantive operation of the Service, even though it might well have unintended adverse effects. It should be emphasized that under the longstanding provisions of the Canteen Service statute, the Secretary bears statutory responsibility for the operation of the Service. The Secretary's authority to delegate or assign specific duties relating to the Service to other VA officials does not have the effect of transferring that responsibility. And any officials making decisions about the Service under any delegated authority must ultimately answer to the Secretary for those decisions and implement policy approved by the Secretary. Section 304(b) would not enlarge the Secretary's ultimate responsibility for the Service, but only prevent the Secretary from carrying out that responsibility through delegation of authority. In our view, it would be counter-productive to limit the Secretary's discretion to provide for the management of the VCS, especially since he bears ultimate responsibility for the VCS' operation whether he delegates related duties or not.

Finally, the Secretary need not directly supervise VCS to ensure that it accomplishes its mission. All VA officials must act consistent with law, as well as their delegated duties, in carrying out policies established by the Secretary for the Service. Problems may arise but, as for any other element of the VA, can be resolved through appropriate action by the Secretary or other officials acting in his behalf. Those policy disagreements regarding the operation of the Service, which sparked the introduction of similar legislation last session, do not reflect an inadequacy in the VCS statute, but rather sincere differences over particular means adopted to implement the statute. We do not believe that legislation mandating organizational changes is warranted or will avoid the adoption of policies over which reasonable individuals may differ.

We estimate that the total cost of S. 901 would be approximately $70.0 million for Fiscal Year 1990, and $595.4 million over five fiscal years. Nearly half the five-year cost would be to fund the nurse special pay provision of section 101.

DRAFT BILL

Mr. Chairman, in inviting us to testify today, you also asked that we comment on a draft bill which your staff furnished to us.

EXTENSIONS OF COMMUNITY NURSING HOME CARE

Section 1 of the draft bill addresses the VA's authority to extend beyond a six-month limit the duration of contract nursing home care provided to nonservice-connected veterans. It would rescind an April 1988 change VA made to the regulation governing such extensions. That regulation change clarified the criteria used to determine if an extension should be granted, and limited the duration of such extensions.

Section 620 of title 38 authorizes the Secretary to transfer to a community nursing home a veteran who was furnished care in a VA medical facility but who still requires nursing home care. The section is intended to provide temporary assistance to a veteran during a period of transition from VA hospital care back to the community. In authorizing this benefit, Congress emphasized that VA's role was simply to provide temporary, transitional support, and that the duration of VA-paid community nursing home care for a nonservice- connected disabled veteran is limited to six months unless, in the exceptional case, a longer period is warranted in the judgment of the Administrator. It should be emphasized that this time limitation does not apply to nursing home care for service-connected disabilities. In all other cases, however, it was clearly the intent of Congress that an extension of community nursing home care beyond six months is to be an exception and not the norm.

Prior to April 1988, the applicable VA regulations lacked well defined criteria for granting extensions, and as a result there was inconsistency in practices regarding granting extensions. The new regulation sought to achieve equity through the application of well defined criteria. Thus, it authorized facility directors to grant an extension beyond six months when the veteran is terminally ill and life expectancy has been medically determined to be less than six months, and to grant an extension of up to forty-five days when arrangements for payment for nursing home care have been delayed unexpectedly. In the latter situation, authorizing a forty-five day extension helps clarify for all VA facilities the circumstances for an extension, and also reduces the possibility of uneven application of this authority. Moreover, the 45-day extension period should afford sufficient time to permit arrangements to be finalized for public (usually Medicaid) or private payment for nursing home care.

To rescind the regulation, and reinstate the regulations existing prior to April 1988, as section 1 would do, would reinstate a set of poorly defined criteria for granting extensions, which would return us to a situation in which veterans in different locations were treated differently, and would likely result in substantial additional costs. For these reasons, we oppose enactment of this provision.

GERIATRICS AMD GERONTOLOGY ADVISORY COMMITTEE REPORTS

Section 2 of the draft bill appears aimed at clarifying that the VA's Geriatrics and Gerontology Advisory Committee must make reports to the Secretary regarding its activities. The statute now provides that the Committee make such reports as it considers appropriate. This measure would provide that reports be made "from time to time." It would also shorten from 90 days to 30 days the period of time given to the Secretary to review the report, prepare comments and recommendations, and transmit the report, comments and recommendations to the appropriate committees of Congress. Although it appears unnecessary, we do not object to the change which calls for reports from time to time. We do question, however, the shortening of the period of time for reviewing the report and submitting it to the Congress. In our view, more than thirty days is needed to obtain a thorough and thoughtful review of such a report, and transmission of the report to the committees.

REPORT ON PROVISION OF PROSTHETIC SERVICES

Section 3 would amend 38 U.S.C. § 614 to reword subsection (a), and add a requirement that the Secretary annually report to the Veterans' Affairs Committees regarding delays VA experiences in furnishing veterans with fitting and training in the use of prosthetic appliances.

We recognize that there have been delays in providing certain prosthetics services, and we share your concern over this problem. To address the matter, we will soon be issuing guidance to Directors of our medical centers to require that they give a higher funding priority to providing these services. Considering the fact that we are attempting to correct the problem administratively, we view the imposition of a new reporting requirement as unnecessary. Accordingly, we cannot support this provision of the bill.

FURNISHING INFORMATION TO THE DEPARTMENT OF EDUCATION

The measure would also add a new subsection (c) to 38 U.S.C. § 3302, to require that the Secretary of Veterans Affairs provide the Secretary of Education with whatever information the latter may require to establish that a veteran is disabled and unable to make payments on installment loans guaranteed by the Department of Education. We strongly object to this provision which has much wider implications for the VA than simply providing this information to the Department of Education.

VA health care professionals are repeatedly asked to provide information regarding the "disability" status of persons treated in VA facilities. These requests come from state and local Governments, other Federal agencies, and various private entities and individuals. For example, we are often asked by individuals to certify that they are disabled so they may obtain some benefit. We have a very longstanding policy of making the health care records of individuals treated in our facilities available, with their consent, for use by these third parties to determine if a disability exists. However, our mission is to provide health care services to veterans, not to make disability determinations for third parties.

H.R. 1199

Mr. Chairman, I next turn to H.R. 1199, another bill aimed at assisting VA in the recruitment and retention of registered nurses. This bill would accomplish a significant restructuring of the VA's nurse pay system.

The approach taken in this bill is in some respects consistent with preliminary ideas our own nurse pay task force is developing. Again, however, we prefer that this task force continue its work and develop a proposed revision of the title 38 nurse pay system, and that the proposal be developed and reviewed through the normal legislative process.

The bill would add a new section 4107A to Chapter 73 of title 38, to govern the grades, rates of pay, and administration of nurse pay. The proposed new pay system would compress the current "eight grade" pay structure into four grades, each with 20 equal step increments. Each of the new grades would correspond to a specified range of grades on the title 5 General Schedule. Thus, the new "Entry Grade" would correspond to GS 6-10, the "Intermediate Grade" would correspond to GS 9-12, the "Senior Grade" would correspond to GS 12-14, and the "Director Grade" would correspond to GS 14-16. The lowest and highest step in each grade would correspond to the lowest and highest step on the corresponding range of General Schedule grades.

The new section 4107A would also provide that nurses who perform satisfactorily must receive a step increase at least once every two years. If promoted within the grade, they must receive a step increase, and if promoted to a higher grade, they must receive a higher rate of pay than before the promotion. Individuals serving as head nurses would be paid at a rate two steps above what they would otherwise receive. In a provision similar to existing authority, the measure gives medical center directors authority to provide step promotions or cash bonuses to nurses with qualifications, experience, or achievements which exceed the standards for that nurse's grade.

Another very significant provision of the bill would authorize the Secretary to permit medical center directors to appoint nurses at pay rates higher then would otherwise be applicable, if the director determines that a higher rate is necessary to hire nursing staff. A director may authorize the higher pay rate only if necessary to provide pay that is competitive with nurse pay in the local labor market, to achieve adequate staffing at the facility, or to recruit nurses with specialized skills. The director must justify the higher rate of pay in writing, and submit the justification with the first budget submission made after the increased pay rate is authorized. If a nurse from a facility with such increased pay rates transfers to a facility that does not pay higher rates, it would be permissible to reduce that nurse's step within a grade, if necessary to be consistent with the pay structure at the new facility. That nurse's pay grade could not be reduced, however.

A final provision in the bill would modify the existing limitation on the amount of overtime that may be paid to nurses. Current law permits payment of overtime at one and one-half times the nurses basic pay rate, but caps the overtime rate at one and one-half times the basic rate for a nurse in intermediate grade. This bill simply removes the cap.

Mr. Chairman, our task force is examining various proposals, including this one, for a new pay system for VA nurses. In general, we do believe that a revised, simplified schedule of pay, in lieu of the present complicated system of basic pay and special salary rates, may be preferable as long as the new system provides the flexibility to target resources to areas experiencing the most difficulty in recruiting and retaining nurses, and avoids pay benefits in geographic areas where upper pay bands are not necessary to meet market conditions.

We estimate that enactment of H.R. 1199 would result in additional costs of approximately $36.0 million in Fiscal Year 1990, and $198.0 million over five fiscal years. Again, because these additional costs are unfunded, the additional pay called for by this measure necessarily would have to come from existing salary funds.

VA DRAFT BILL

Finally Mr. Chairman, you asked that we provide comments on a draft bill to authorize a leave sharing plan, a bill that we asked you to introduce on behalf of the Administration.

The leave transfer program currently in effect allows covered employees to apply, based on a personal emergency, for eligibility to use the unused and accrued annual leave of other employees. Personal emergency means a medical or family emergency or other hardship situation, a minimum of ten workdays, likely to result in a substantial loss of income to the employee because of the unavailability of paid leave. Employees who wish to donate leave submit voluntary written requests specifying the amount of leave they wish to donate. The donating employer's account is then reduced by the amount of leave he or she asked to donate and the eligible recipient's leave account is augmented. When the emergency terminates, unused donations of leave are restored to the appropriate donors. An employee may not donate leave to his or her supervisor or give more than half the leave he or she would accrue during the year of the donation.

The Federal Employees Leave Sharing Act of 1988, Public Law 100-566, provided authority for a five-year leave sharing program. That program allows covered employees to apply, based on a personal emergency, for eligibility to use the unused and accrued annual leave of other employees. Personal emergency means a medical or family emergency or other hardship situation, a minimum of ten workdays, likely to result in a substantial loss of income to the employee because of the unavailability of paid leave. Employees who wish to donate leave submit voluntary written requests specifying the amount of leave they wish to donate. The donating employee's account is then reduced by the amount of leave he or she asked to donate, and the eligible recipient's leave account is augmented. When the emergency terminates, unused donations of leave are restored to the appropriate donors. An employee may not donate leave to his or her supervisor or give more then half the leave he or she would accrue during the year of the donation.

Although earlier (and more narrow) one-year leave transfer authorities (Public Laws No. 100-202 and 100-440) allowed including the health care professional employees in the Department of Veterans Affairs, who are appointed under the special authority in title 38 of the United States Code, the new five-year leave sharing law does not cover those "title 38" employees. Those employees include physicians, dentists, nurses, podiatrists, optometrists, physician assistants, and expanded-function dental auxiliaries. The one-year authority will be expiring September 30, 1989. The draft bill would authorize a five-year leave sharing program covering those "title 38" employees, giving discretion to include them in the benefits of both leave transfer and leave banks over its five year term.

The draft bill would amend title 38 of the United States Code to authorize the Secretary to establish a leave sharing program, similar to that authorized for title 5 employees under the current laws, and would thus allow the Department to continue including health care professionals in leave sharing, a very helpful means of assisting personnel who, through a medical emergency, find themselves threatened with loss of pay because leave resources become exhausted. The leave sharing program established by this draft bill would be consistent with current Office of Personnel Management regulations governing leave sharing programs. The bill also provides for repeal effective October 31, 1993.

The draft bill, by including the title 38 workers in a system already available to title 5 employees, would allow equal eligibility for all employees and would facilitate management of leave sharing. Also, the draft bill would permit the

Department to avoid the possible adverse morale implications of having part, but not all of a large group of employees, be eligible for participation.

The temporary leave transfer authority, which has affected both title 5 and title 38 employees, has worked smoothly and helped employees cope with leave emergency situations. It is therefore expected that the authority in the draft bill could be implemented efficiently and helpfully. The five year authority would enable the Department to assess the benefits and implications of leave sharing vis a' vis its unique health care professional employees.

We estimate no additional costs will result from enacting this draft bill except for negligible administrative costs.

Mr. Chairman, this concludes my prepared statement. My colleagues and I would be pleased to respond to any questions you may have.

BLINDED VETERANS ASSOCIATION
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LEGISLATIVE STATEMENT BEFORE THE

HOUSE COMMITTEE ON VETERANS AFFAIRS

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

SUBMITTED BY

THOMAS H. MILLER, DIRECTOR OF GOVERNMENTAL & COMMUNITY RELATIONS

APRIL 12, 1989

Mr. Chairman and members of the Subcommittee, the Blinded Veterans Association (BVA) is pleased to have this opportunity to express our views on proposed legislation to amend Title 38 U.S. Code to make certain improvements in VA health care programs. In accordance with your letter inviting BVA to appear this morning, we will restrict our comments to just two of the three sections of this draft bill, Section 1 and 3. While Sections 1 and 2 of this draft legislation address problems with a rather short history, Section 3 addresses an area which has been a chronic problem for years.

SECTION 1. COMMUNITY NURSING HOMES

BVA fully supports rescission of VA regulations which place arbitrary limitations on the length of Nursing Home Contracts for the care of NSC veterans. We strongly feel that termination of care should be a medical decision not an arbitrary administrative decision as a means of saving money. The delivery of quality health care is contingent upon reliance on high quality health care professionals and carrying out appropriate orders from these professionals. When financial planners and managers begin making decisions which directly impact the delivery of quality health care, we have serious problems. It seems likely to us that such arbitrary termination of care, regardless of the medical condition, will only contribute to the revolving door phenomena in the VA. Veterans will experience relapses requiring re-hospitalization and possible placement once again in the community nursing home. This is not cost effective delivery of service or good medical practice. Whatever savings might have been realized by early release from the contact home, will be lost in having to treat the same condition all over again.

We recognize the fiscal crisis being faced by the Veterans Health Care and Research Administration (HCRA) and the need to curtail expenditures, but this cannot be done at the expense of quality health care as promised by the Chief Medical Director (CMD). Possibly accelerating the conversion of VA unused or unneeded VA acute care beds might decrease reliance on contract community nursing home beds. We do caution however, that should feasible alternatives to negate this dependency on contract community based nursing homes and this section of this legislation should pass Congress, sufficient funds must be appropriated to implement this provision to insure the delivery of quality nursing home care. In the absence of sufficient funding, HSRA will once again be forced to divert funds from other programs and services a practice leading in part, to the current crisis in VA health care. If the DVA is to honor its commitment to provide quality services, programs must be driven by medical needs, rather than by the bottom line of a balance sheet.

SECTION 3. ANNUAL REPORT ON DELAYS IN ORDERING PROSTHETIC SERVICES

As mentioned above, the delivery of prosthetic services has been a chronic problem that Veterans Service Organizations (VSO's) have been complaining about for years. BVA is no exception -- we receive complaints all the time from blinded veterans over long delays or other problems in securing prosthetic and sensory aids vital to their ability to function independently on a daily basis. Delays in ordering result either from lack of financial resources, or inefficiencies, or negligence in processing requests. Severely disabled veterans can at least understand the former, but the latter is intolerable. From a managerial perspective, the latter problem should be more manageable and responsive to supervisory controls. Another contributing factor to this problem may also be the lack of sufficient Full Time Employee Equivalents (FTEE), resulting in increased work loads for employees on hand. As we all recognize, inefficiencies and work load back ups often result from inadequate staffing.

Mr. Chairman, adequate funding for the provision of Prosthetic Services is crucial to efficient prompt ordering of those services. The VA, however, does not appear to have an appropriate mechanism for making this determination. Money supposedly designated for Prosthetic Services, is included in the local VAMC health care account and there is no line item in that account for those services. The local medical center director has the management flexibility to utilize the funds in his health care account as he deems necessary to maintain the programs and services offered at this facility. It has long been contended that funds appropriated or allocated for Prosthetic Services are utilized for other programs and services, but there is no reporting mechanism to verify this contention one way or another. Consequently, it is unclear whether sufficient funding has been provided to the local installation for prosthetics or sufficient dollars were allocated, but spent on other services. We believe it is crucial to be able to answer this question in order to develop any rational plan for improving the delivery of prosthetic services.

Mr. Chairman, we commend you and this Committee for your commitment to insuring the timely delivery of prosthetic services evidenced by this legislative proposal to amend Title 38 U.S. Code, Chapter 17, Section 614 to improve the delivery of such services. We are aware however, that reports similar to the one proposed in this legislation have been requested and submitted in the past with no apparent positive results. Certainly we are not opposed to codifying such reporting. The acquisition of this information is vital for planning purposes, as well as a management tool for evaluating the performance of those charged with the responsibility of providing prosthetic services and properly managing the funding appropriated for such services.

The collection of such data cannot be an end in itself, but a tool to develop action plans to correct deficiencies uncovered by the data collection. To the extent codifying this process can enhance the development of corrective action plans, we are totally supportive and urge passage of this legislation. Additionally however, we believe this is only a first step towards making necessary corrections to a flawed process which requires urgent attention.

BVA is aware of the Prosthetic Task Force appointed by the CMD, to fully explore Prosthetic Services and recommend remedial actions to correct identified problems. We, in fact, had an opportunity to comment on the recommendations of that Task Force, and generally concurred with all the recommendations. We do believe however, the Task Force did not go far enough regarding recommendations to deal with the single most fundamental problem--the allocation of funding and protecting those funds for the support of Prosthetic Services alone. The Task Force recognized that a funding problem exists, but did not recommend establishing a centralized source of funding from which all services would be purchased, nor did they recommend fencing those funds allocated to the local facility in the health care account. In our opinion, it is imperative some controls be placed on these funds, so an exhaustive study can be completed to determine just where these funds are being expended. Although we can understand the need for managerial flexibility on the local level and the desire to remain free from "micro-management", we remain unconvinced these managers are sensitive to the need for quality prosthetic services for disabled veterans these managers are mandated to serve.

After carefully reviewing this proposed legislation to improve the ordering and delivery of Prosthetic Services, BVA would like to raise two other issues associated with the funding of such services which the legislation does not and cannot address, but we want you to be aware of. First, in Section 614, subsection (a)(1) describes Prosthetic Services and the mechanisms for providing such services to eligible veterans. The proposed legislation would amend this section to add (2) to subsection (a), adding the annual reporting requirement. Our concern relates to subsection (b) of Section 614. This subsection describes the provision of dog guides and special electronic equipment to eligible blinded veterans. The provision of these latter prosthetic services apparently would not be included in the proposed reporting in subsection (a)(2). We are especially concerned about the provision of special electronic equipment such as computers. Prosthetic and Sensory Aids Service has no definitive policy regarding such issuance and handles requests on an individual basis.

One of the stipulations with which we fully concur, prior to issuance, is having received training on the device with demonstrated need and ability to utilize the equipment. We have for the past several years, been strongly supporting a proposal submitted by Blind Rehabilitation Service in VACO to establish Computer Evaluation and Training Programs in the four blind rehab centers. Unfortunately, this proposal has been rejected because of the budget crisis and desire to reduce the budget deficit. As a consequence, two of the blind centers have attempted to provide such training using existing resources and veterans must wait months to be scheduled for this specialized training.

Problems have also developed once a vet has completed the training, over who is going to purchase the recommended equipment; the blind center, which is not funded for this function; or the local prosthetic clinic of jurisdiction for the blinded vet. In recognition of the fiscal problem, BVA suggested to the CMD in correspondence last summer, that a Pilot Project be funded and established at one BRC -- Western Blind Rehab Center (WBRC) at VAMC Palo Alto. This project could then be evaluated and expanded to the other BRC's as funding became available. (See Attachment A)

Mr. Chairman, the funding necessary for such a pilot project is not "budget busting" and is crucial to the provision of necessary prosthetic services to severely disabled veterans. Based on the budgetary shortfall reported by Prosthetic and Sensory Aids Service for FY 88 ($10 million), it is clear additional funding must be provided for Prosthetic Services and we request the special needs of blinded veterans be considered when determining what additional resources are required.

The second concern related to Prosthetic Services not covered by this bill is the mechanism for funding the provision of Prosthetic Services at the BRC's. These programs are regional and in some cases multi-regional in nature, receiving referrals for blind rehab training from many states. However, the host VAMC is expected to provide the necessary prosthetic equipment to blinded veterans in training. Should the host facility experience a reduction in their budget, they must continue to provide the same services to those blinded veterans. We recommend that some mechanism be established for the referring stations to share in the expense of the prosthetic services provided. This recommendation does not require new or additional funding, only a method for reallocating existing levels of funding to support this crucial activity. We believe such a system would be equitable and greatly relieve the host VAMC from the extra burden and pressure on their health care account. We have made this recommendation to VA officials with no result, and respectfully request that if the Committee finds merit in the proposal, they urge VACO to seriously consider implementing such a plan.

Finally, Mr. Chairman, BVA appreciates this opportunity to express our views on this important legislation and as always pledge to work with you and the Committee in any way possible to enhance the quality of life for our nation's veterans. For those who are severely disabled, the timely provision of prosthetic services is absolutely essential to enhance the quality of life.

Attachment A

BLINDED VETERANS ASSOCIATION

477 H STREET, NORTHWEST • WASHINGTON D.C. 20001 • (202) 371-8880

July 22, 1988

Veterans Administration
Dr. John A. Gronvall
Chief Medical Director(10)
810 Vermont Avenue, NW
Washington, DC 20420

Dear Dr. Gronvall:

In recent years, The Blinded Veterans Association (BVA) has passed resolutions in Convention encouraging the establishment of Computer Evaluation Training Programs (CETP) at the VA Blind Rehab Centers. We are aware that such a proposal was submitted in the FY1989 budget request, but was eliminated prior to the request leaving the agency. The proposal called for establishing two such programs in FY1989 and the remaining two in FY1990.

When we learned that the CETP was eliminated from the budget request that was forwarded to The Office of Management and Budget (OMB), we expressed our disappointment to the Administrator in a letter (enclosed) dated September 10, 1987. In his response (enclosed), he indicated the request would be submitted again.

We are acutely aware of the fiscal constraints the VA is having to operate under and can appreciate the need for careful review of new spending initiatives, but we feel the CETP is most worthy of careful consideration and resubmission for the FY1990 budget request. It is in keeping with the Administrator's personal commitment to hiring the handicapped, especially disabled veterans and could prove to be a very cost effective program for the VA. The advancements in computer technology have opened many new doors to the handicapped, particularly the blind, and the VA is in a unique position to provide blinded veterans with the evaluation, training, and the necessary tools to take advantage of these new employment opportunities.

Sensitive to the severe budgetary problems confronting the VA, a possible alternative to the proposal submitted last year might be to request funding for just one CETP. This program could be established as a Pilot Program and we would recommend The Western Blind Rehabilitation Center at VAMC Palo Alto, CA. The Palo Alto Blind Center has been in the forefront of computer evaluation and training to date and would be in the best position to take advantage of the additional resources.

Dr. Gronvall, we are most appreciative of your sensitivity to the needs of blinded veterans and your enthusiastic support for programs and services to

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effectively address these needs. We strongly encourage you to make every effort to make funding available for at least a CETP Pilot Project.

Thank you again for all your support and your careful consideration of this extremely important issue.

Very Sincerely,

Thomas H. Miller
Director of Governmental &
Community Relations

Enclosures

BLINDED VETERANS ASSOCIATION
1726 M STREET, NORTHWEST, SUITE 800 • WASHINGTON, D C 20036 (202) 223-3066

September 10, 1987

Veterans Administration
The Honorable Thomas K. Turnage
Administrator(00)
810 Vermont Avenue, NW
Washington, DC 20420

Dear General Turnage:

The Blinded Veterans Association (BVA) having recently concluded our 42nd National Convention, returned home with a number of resolutions passed in convention assembled upon which national headquarters staff was instructed to pursue. One such resolution had to do with a Computer Evaluation and Training Program proposed by Blind Rehabilitation Service. This proposal called for the provision of appropriate FTEE and equipment to establish the program at two of the Blind Rehab Centers in FY 1989 and the remaining two in FY 1990. The BVA wholeheartedly supports this program and in fact has passed resolutions over the past several years encouraging the establishment of such a program. We were deeply distressed to learn upon returning home that the request for FY 1989 had already been eliminated from the budget request sent to The Office of Management and Budget (OMB).

The BVA is most cognizant of the need for and the pressures to reduce the budget deficits and the role each federal agency must play in this process, but we were very disturbed to learn that such an important program to blinded veterans was eliminated. We do not feel the proposal is in any way budget busting and in fact can do much to assist in helping severely disabled veterans return to meaningful employment and the tax roles.

Historically, the blind have been one of the most difficult disability groups to place in meaningful employment and now technology provides the means for blinded individuals to be competitive with the sighted for meaningful jobs. All the technological advances in the world mean nothing however if blinded veterans do not have access to the equipment and the training necessary to become proficient in its use. This problem is not unique to blinded veterans alone; all blind Americans are experiencing difficulty in gaining access to equipment that open many previously unopened doors with respect to employment. The VA has been a pioneer and world leader in the field of blind rehabilitation and the BVA feels it can also provide the leadership in evaluating computer equipment accessible to the blind and the training of blind individuals in the use of this equipment in a wide variety of employment situations. Currently, blinded veterans are being accepted in the VA blind rehab centers for computer evaluation and training but at the expense of the regular adjustment to blindness program. There are long waiting

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lists for all four centers for the regular program which is so crucial to a veteran's adjustment to and acceptance of his sight loss, as well as the acquisition of blind skills necessary to overcome the handicap of blindness. It is not realistic to think of education or employment until an individual has successfully completed a basic rehabilitation training program. We are concerned that having to use regular program beds for special programs like computer evaluation and training only further delays the basic rehabilitation so essential to all blinded veterans. The Computer Evaluation and Training Program proposal calls for two additional beds at each facility for this program, so as not to detract from the regular program. The other negative aspect of having to use existing regular beds for computer training is extremely long waits for available beds for such training at VAMC Palo Alto until March of next year. How long is it realistic for us to expect an employer to wait for a person to receive necessary training in order to be employable? We feel certain that a blinded veteran should be employment ready when he begins interviewing and this means having all the skills necessary including computer training.

Securing employment is not the only problem. Those blinded veterans who have already been fortunate enough to find employment, may need computer evaluation and training for upward mobility. This is another chronic problem faced by blind persons historically. Again, as with finding employment, advancement opportunities may not wait indefinitely for the individual to get necessary training and access equipment.

For these reasons, we feel the VA proposed Computer Evaluation and Training Program is vital to our employment futures. Without computer technology, I would be at a distinct disadvantage in my chosen profession. I currently am a Deputy District Attorney for San Diego, CA and am expected to effectively prosecute on a daily basis those who are accused of breaking the law. I would be extremely hard pressed to keep up with my demanding schedule if I did not have the use of computerized equipment provided by the VA. In addition to the Kurzweil Reading Machine (KRM) and the Versa-brailler, I have a Lap-top Computer with speech output which I use daily in court. The latter device is a more recent break through in computers and is invaluable to me. To be sure, I am most grateful to the VA for the equipment and training I have received, but I am only one of a very few. It is the hope of the BVA that many more blinded veterans can have the sam opportunities as I have had. We are convinced from our experience that the proposed Computer Evaluation and Training Program can help this become a reality.

We want to take this opportunity, General Turnage, to thank you for considering this very important issue and sincerely hope you will be able to reconsider the decision to not fund the program and restore it to the budget request for FY 1989. The BVA is most appreciative of your sensitivity and support of programs and services vital to the rehabilitation and well being of blinded veterans and indeed all severely disabled veterans. We look forward to hearing from you soon regarding this program of vital concern to BVA.

Very Sincerely,

David M. Szumowski

David M. Szumowski
National President

Enclosure

STATEMENT OF

ROBERT MANHAN, SPECIAL ASSISTANT
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

VARIOUS LEGISLATIVE PROPOSALS

WASHINGTON, D. C. APRIL 12, 1989

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

Thank you for the opportunity to appear before this distinguished body to present the views of the Veterans of Foreign Wars of the United States with respect to proposed legislation that addresses administrative, personnel and management issues to improve hospital and health-care services to and for veterans. The VFW very much appreciates the work and effort this important Subcommittee has expended by holding this hearing. This action demonstrates once again your continuing concern for and support of our nation's veterans, their dependents and survivors.

The VFW will comment on each and every topic starting first with H.R. 1199, followed by H.R. 901 and concluding with the draft bill dated March 23, 1989.

H.R. 1199 is offered by Mr. Kennedy and several members of this Subcommittee. The short title is "Veterans Nurse Pay Act of 1989." The overall intent of the bill is to improve recruitment and retention of nurses in Department of Veterans Affairs (DVA) by providing greater flexibility in the pay system for registered nurses. The VFW also recognizes the fact that the cost-of-living does vary significantly from place to place within the United States and this is one of the factors that has a profound effect upon the recruiting and retention of registered nurses. While we do recognize and appreciated the intent of H.R. 1199, we believe this bill could have the effect of limiting the Secretary's flexiblility with respect to solving this problem. However, the VFW looks forward to working with the Committee to further develop and possibily expand upon this proposal because it does address the critical issue of not having enough nurses everywhere in the DVA system.

H.R. 901 is offered by the Chairman of the House Veterans' Affairs Committee and has a great many Committee cosponsors.

Title I--Personnel Provisions—addresses special pay for registered nurses in section 101 and premium pay for licensed practical or vocational nurses and nurse assistants in section 102. Both sections are efforts to improve the salaries of these career health-care employees. We note the pay increases would be mandatory and the program would be a centralized policy. The VFW is in agreement with efforts to provide wage and salaries that are competitive to those paid nurses in the private or non-federal sector of the labor market. We recognize this proposal as one effort to recruit and retain nurses with needed specialized skills to achieve adequate staffing throughout the entire DVA medical system. We also recognize the potential problem of having a nursing staff that could become, over time, very expensive because of seniority.

Section 103 deals with Clarification of Certain Limitations with Respect to Employment. The VFW agrees with the administrative proposal to allow a title 5 employee to obtain employment outside DVA provided there would be no obvious conflict of interest with his/her DVA duties or responsibilities. And we view the proposal to attract retired military registered nurses as a necessary and positive step by expanding DVA's authority to grant an exception to the reduction in retired military pay.

Section 104 deals with Appointment of Certain Individuals in Health-Care Positions. The VFW again strongly supports efforts to expand DVA's authority to selectively recruit fully qualified personnel in the health-care profession or health-care occupation presently working in the private section.

Title II deals with Health Program Amendments. The VFW applauds the Committee's action to make respite care services a permanent entitlement. We also support the extension of the State Home Grant Authority for an additional period of three years to September 1992 from September 1989. We recognized this as a relatively inexpensive, cost effective and very necessary effort to address and help solve the serious requirement for furnishing domiciliary or nursing home care to the aging veteran population.

Section 202 addresses the "Homeless Veterans' Program." The VFW concurs with the proposed legislation to look at alternatives to assist this category of veteran. We believe the philosophy of a "half-way house" is a positive step to help return as a productive member of society those individuals who do not require a more extensive and lengthy support system. We also support both administrative changes in the compensated work therapy (CWT) program; first to make more housing available to CWT veterans and second, to allow DVA to contract with all sectors of the rehabilitative service market. We believe this free enterprise approach will work to everyone's advantage.

Title III deals with the issues of Health-Care Management. The VFW is concerned about the proposed legislation cited in section 301, the "Pilot Program for Improved System for Collection of Fees." This calls for a two-year pilot program in one Department of Medicine & Surgery (DM&S) medical region. The test program would apply to fees charged to third parties, amounts due DVA under cost sharing agreements, amounts DVA may recover from insurance companies or other third party payers and/or copayments veterans agree to pay to receive DVA care. The provisions would also direct the allocation of the funds collected, and the uses the funds may be put to by the DVA. The VFW has in the past supported the concept of an automated billing and collection system, and we again support this test project. Our only concern is that veteran services are not degrated by a shifting of priorities or resources from the direct provision of health-care.

Section 302 addresses the issue of Eligibility of Military Dependents for Health Care Under Sharing Agreements. The VFW has serious concern with this proposal to expand the DVA entitlement of "primary beneficiary" to dependents of active duty military personnel at this time. Our rationale for this position is twofold. First, the DVA presently cannot/is not providing the care and services authorized by existing legislation to all veterans who request such care. Second, we believe there is enough latitude in current language of title 38, to accommodate these dependents on a case-by-case basis without a formal extension of a DVA entitlement to such a large class of non-veterans. However, the VFW does recognize that this proposal is an effort to expand and formalize the sharing of DVA-Department of Defense (DOD) health-care resources. The VFW believes this is a very important area for future positive, mutually beneficial actions.

Section 303 Civilian Health and Medical Program of the Veterans Administration (CHAMPVA) Program. The VFW strongly supports any and all actions to ensure that only those entitled to DVA benefits receive them. In this particular instance we support efforts to ensure that only the proper spouse or surviving spouse and or child(ren) of permanently disabled service-connected veterans or those veterans who died as a result of a service-connected disability who also had a total permanent disability, or to family members of active duty personnel who die in the line of duty are listed by name for an entitlement.

Section 304 deals with two different issues regarding the canteens at hospitals and homes throughout the DVA system. The first issue addresses the operation of the canteen service. The VFW would prefer not to add the provision that would limit the source of who the service may sign an agreement or contract with for goods and services. The VFW is more interested in seeking the best possible array of merchandise and services available at competitive prices for the use and benefit of those veterans who are primarily hospitalized or residing in domiciliaries. The second issue deals with the managerial concept of ensuring that the canteen service function as an independent unit of the DVA by requiring the head of this activity to report to or be supervised only by the Secretary and Deputy Secretary of the DVA. The VFW will support an action that will ensure that the needs and the reasonable desires of confined veterans everywhere in the DVA system are addressed in a prompt manner. We are most interested in providing the largest selection of merchandise and/or services in a clean, courteous and congenial atmosphere. If this goal can be achieved only by centralizing the supervision, than the VFW supports the proposal.

Section 1 of the Discussion Draft proposes to remove the 45 day limit for use of community nursing home care facilities. The VFW concurs in this action primarily because we strongly believe this period of time is not long enough to benefit veterans in most cases.

Section 2 deals exclusively with the issue of requiring DVA to submit its reports of geriatrics and gerontology to Congress within a 30 day period of time as opposed to the present 90 days. The VFW supports efforts to obtain meaningful information in a timely manner just so long as the proposal is to improve service to the veterans. This same general comment applies to Section 3 wherein DVA is required to submit a new report annually regarding delays in ordering prosthetic services.

Last is a separate legislative draft designed to exchange information between the Secretary of DVA and Secretary of Education in order to assist veterans who are eligible for deferment on loans made under the Guaranteed Student Loan Program in those instances where the veteran is temporarily totally disabled. The VFW believes this is a compassionate and necessary action.

Mr. Chairman and members of the Subcommittee, this concludes my statement. I will be happy at this time to answer any questions you may have. Thank you.

STATEMENT OF
FRANK R. DEGEORGE, ASSOCIATE LEGISLATIVE DIRECTOR
PARALYZED VETERANS OF AMERICA
BEFORE THE
HOSPITALS AND HEALTH CARE SUBCOMMITTEE
OF THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
CONCERNING
H.R. 901, the "Veterans' Health-Care Programs Amendments of 1989";

H.R. 1199, the "Veterans Nurse Pay Act of 1989"; and

DRAFT LEGISLATION pertaining to the ordering of prosthetics devices and services, limits on the provision of community nursing home care at Department of Veterans Affairs expense, changing the reporting requirements of the DVA's Geriatric and Gerontology Advisory Committee and legislation regarding the authority for DVA physicians to assist veterans in meeting certain application requirements for other Federal programs.

APRIL 12, 1989

Mr. Chairman, and Members of the Subcommittee, Paralyzed Veterans of America appreciates this opportunity to present our views regarding the introduction of legislation pertaining to the recruitment and retention of nurses in the Department of Veterans Affairs, and for other stated purposes.

H.R. 901, The "VETERANS' HEALTH-CARE PROGRAMS AMENDMENT OF 1989."

H.R. 901, if enacted, would significantly improve the Department of Veterans Affairs' (DVA) ability to recruit and retain nurses and other "hands-on" health-care personnel. The provisions included in this legislation would go a long way in relieving the critical shortages being experienced by DVA Medical Centers in these important health-care fields.

TITLE I--PERSONNEL PROVISIONS

SEC. 101. SPECIAL PAY FOR NURSES.

PVA supports and firmly believes that the incorporation of "special pay for nurses" is critical in the overall enhancement of the nursing program. DVA can only attract and retain these individuals if they are properly compensated for their expertise and special abilities. By addressing such issues as tenure, overtime, professional expertise, and other special attributes, you have properly included these individuals in the "highly qualified" category along with physicians and dentists. This measure will go far to assist in correcting the most serious problem facing the DVA which is the lack of adequate staff. We applaud the efforts of Chairman Montgomery for introducing this measure. Meanwhile, we continue to seek and question where are the Agency's staffing guidelines?

SEC. 102. PREMIUM PAY FOR LICENSED PRACTICAL OR VOCATIONAL NURSES AND NURSE ASSISTANTS.

PVA also supports this section which would enhance compensation for licensed practical and vocational nurses and nurse assistants. Accordingly, these individuals would be appropriately elevated to a level of premium pay which would truly reflect their worth.

In PVA's opinion this equitable amendment is both a positive and appropriate recruitment, retention and recognition tool. It is necessary as private-sector hospitals competing for the same ever-dwindling pool of health-care personnel have been offering premium pay and other various incentives for years.

SEC. 103. CLARIFICATION OF CERTAIN LIMITATIONS WITH RESPECT TO EMPLOYMENT.

PVA supports Section 103 of your bill which properly clarifies certain limitations that apply to the outside employment of DVA health services personnel. Individuals such as physical therapists, respiratory therapists, LPN's, and pharmacists are presently hired under title 5, U.S.C., but paid under title 38, U.S.C. Although title 5 permits outside employment, the Department has been restricting these individuals to the provisions which govern those employees hired under title 38. By specifically permitting therapists, LPN's, and others to obtain outside employment, you have properly enforced an important recruiting and retention tool through this legislation.

Although we are supportive, it is important that the Secretary provide assurances, by enactment of this provision, that quality medical care must not be endangered by staff, who by virtue of a second job, may become overtired, overburdened and/or overworked.

PVA supports section 103 which further enhances the nursing program by permitting nurses to receive their full salary without being forced to forfeit a portion of compensation due to the fact that they are entitled to receive military retired pay. Such nurses represent an extremely valuable asset to the Department. They are experienced professionals whose retainment is critical to the well-being of the Department and veterans as a whole. This legislation would also embellish the Department's ability to successfully recruit from a vast pool of untapped resources from the retired military section.

SEC. 104. APPOINTMENT OF CERTAIN INDIVIDUALS IN HEALTH-CARE POSITIONS.

PVA supports the amendments of Section 4106 which permits the Secretary to appoint qualified individuals in the competitive civil service without certain restrictions. Once again, this provision enhances the DVA's ability to recruit certain highly qualified individuals. It broadens the pool of available talent and further enables the Secretary to provide highly qualified medical staff.

TITLE II HEALTH PROGRAM AMENDMENTS

SEC. 201. EXTENSION OF EXPIRING PROGRAMS.

PVA strongly supports your amendment to make the Respite Care Program permanent and to extend the State Home Grant authority until September 30,

1992. Many of our members, their dependents, and caregivers, have first-hand knowledge concerning the critical support offered by these programs. Those individuals who care for catastrophically disabled veterans share a very special understanding of the challenges which must be faced on a daily basis - challenges that take a heavy toll on the physical and emotional well-being of all those involved. The respite care program provides relief and refuge for this special group and if allowed to expire, would leave an enduring void in the difficult lives of those individuals who currently benefit by it. Your amendments contribute to, in the long term, deinstitutionalization. The programs are sorely needed - they should be maintained.

SEC. 202. HOMELESS VETERANS' PROGRAM

PVA supports this provision which would provide additional relief for homeless veterans by providing transitional housing for these individuals. In addition, your bill would expand the intent of PL 100-198 by allowing those groups which provide "Compensated Work Therapy Programs" to obtain DVA owned property for not less than 75% of the fair market value. We believe this is a good investment in the program and will provide expanded sources of rehabilitation opportunities for disadvantaged veterans.

PVA understands that this program will not have any impact on the Home Loan Guaranty revolving fund or the DVA program in total. It is our belief that this is an extremely innovative and cost effective approach to converting a negative situation into a course of positive action that tentatively could assist homeless and/or rehabilitating veterans.

SEC. 203. COMPENSATED WORK THERAPY PROGRAM.

PVA supports this effort to provide the DVA the ability to extend and expand its services by taking advantage of other programs that can only assist in rehabilitating the veteran. It offers the added potential for the veteran's employment and career opportunity. True success of this cost effective approach, for the veteran and the government, can be measured once the individual assumes a taxpayer's role in our society.

TITLE III--HEALTH-CARE MANAGEMENT

SEC. 301. PILOT PROGRAM FOR IMPROVED SYSTEM FOR COLLECTION OF FEES.

PVA supports this amendment and believes it is an excellent method by which the DVA can re-direct funds into areas that need financial support. We are especially optimistic concerning the potential rewards of this initiative as it pertains to benefits for nurses and additional funding for medical equipment.

We have but one reservation, which is that the DVA must allocate only the authorized and approved appropriations provided for this purpose. They must not use such funds, as they tend to do from time to time, simply for damage control due to poor management practices.

SEC 302. ELIGIBILITY OF MILITARY DEPENDENTS FOR HEALTH CARE UNDER SHARING AGREEMENTS.

Chairman Montgomery, PVA supports this amendment which extends the intent of PL 97-174 to military dependents. Priority of care at both military and DVA medical centers has been properly established by existing law. Extending entitlement to the dependents of military personnel is a necessity if DOD/DVA cost-sharing is to be truly successful. Conversely, the eligible dependents of veterans must be entitled to receive care at DOD facilities. Consideration for veterans' dependents to receive care in DVA facilities as well as DOD facilities should also be examined.

It is clear that active duty military personnel and Category A, B, and C veterans must retain their "priority status" over dependents' care. We therefore encourage this Subcommittee to engage in aggressive oversight regarding this provision if H.R. 901 is eventually enacted. Reports from our National Service Officer in Albuquerque, New Mexico indicates that such a problem may be surfacing.

We must state that our concern is with the ever-increasing demand for health-care services made on DVA by aging veterans. Providing quality of care to veterans is a priority that must never be jeopardized because DVA is spread too thin due to the inclusion of additional groups of eligible beneficiaries. Also, priority medical care for veterans must not be jeopardized by the treatment of dependents whose care will be paid for by D.O.D. Having made these statements, we reiterate our support for this amendment.

SEC. 303 CHAMPVA PROGRAM

PVA has no objection to this initiative. This section seeks a study of alternative methods for providing improved health benefits at lower costs to beneficiaries. We would favor any efforts to save money, especially if such efforts do not adversely affect veterans' medical entitlements.

SEC. 304 CANTEEN SERVICE

PVA favors this amendment which will provide the DVA with the appropriate responsibility and control of the canteen program which is run and operated within DVA facilities. This control is especially important where service is being provided to veterans by an operative that is not administered by the DVA. This initiative offers just plain good business sense. The Canteen Service itself is meaningful as it provides goods and services that lend to the health, welfare, and rehabilitation of the disabled veteran.

H.R.1199 "VETERANS NURSE PAY ACT CF 1989"

PVA supports the provisions contained in H.R. 1199. This measure, in conjunction with H.R.901, provides meaningful incentives that encourage the recruitment and retention of nurses. It also enhances the potential for career opportunity while recognizing "time-in-grade" longevity of the professional health care personnel.

Especially important is the provision for inclusion of geographic cost-of-living pay differentials. Obviously, pay increases should not be provided under this section when station to station transfers occur within cities or locale where there are two DVA Medical Centers in close proximity to each other.

Mr. Chairman, both H.R.901 and H.R.1199, take positive steps to enhance DVA recruitment opportunities in the areas of nursing and other medical personnel. Paralyzed Veterans of America strongly endorses both initiatives since we believe the bills compliment each other and there does not appear to be any conflict between the two. Merger of these two bills, if enacted, would greatly strengthen the DVA's position when competing within the medical community to recruit and retain nurses and other "hands-on" medical personnel.

PVA is grateful to Chairman Montgomery, Representative Joseph Kennedy, and the many co-sponsors who have endorsed these two pieces of legislation. Your combined efforts will ultimately result in better health care for our Nation's veterans.

DRAFT LEGISLATION

PVA is pleased to support every amendment and requirement contained in Chairman Montgomery's draft bill.

SEC. 1. COMMUNITY NURSING HOMES

Regarding community nursing homes, we previously testified in 1988 that the existing regulation, as written, was so rigidly inflexible that it would deny care to otherwise eligible catastrophically disabled and aged service-connected veterans. We commend the Chairman for including this provision in the bill. We are pleased to support this initiative to rescind the DVA regulation.

SEC. 2. SUBMISSION TO CONGRESS OF REPORTS OF GERIATRICS AND GERONTOLOGY ADVISORY COMMITTEE

PVA supports this provision. The reporting of the GRECC'S program is particularly important on a timely basis because it pertains to the future health-care needs of aging veterans and spinal cord injured veterans. Such reports to Congress are critical for various reasons: (1). the dissemination of information is presently difficult to obtain, (2). those responsible for these programs must be clearly identified, and (3). types of "hands-on" treatment and care must be clearly and adequately established.

SEC. 3. ANNUAL REPORT ON DELAYS IN ORDERING PROSTHETIC SERVICES

Mr. Chairman, PVA strongly supports this section of your draft bill. The annual report which your bill requires will provide specific information for this Subcommittee to be thoroughly informed about prosthetic backlogs. Timely issuance of prosthetic services and equipment is one of the most important concerns of disabled veterans. Your recognition of this need is highly appreciated by our members.

FURNISHING INFORMATION TO THE SECRETARY OF EDUCATION

PVA supports this provision which we believe is both compassionate and beneficial in terms of long-range rewards for disabled veterans. The measure will enhance the rehabilitation process of veterans pursuing programs of education.

Mr. Chairman, that concludes my statement. I will gladly answer any questions that you have.

STATEMENT OF
DAVID W. GORMAN
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
FOR MEDICAL AFFAIRS
DISABLED AMERICAN VETERANS
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF THE
HOUSE COMMITTEE ON VETERANS AFFAIRS
April 12, 1989

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the more than 1.2 million members of the Disabled American Veterans and its Ladies' Auxiliary, I am pleased to appear here today to discuss the various issues relating to the Department of Veterans Affairs (DVA) health care system -- the Veterans Health Services and Research Administration (VHSRA).

Mr. Chairman, in your letter of invitation to testify, our views were solicited regarding H.R. 901, the "Veterans Health-Care Programs Amendments of 1989"; H.R. 1199, the "Veterans Nurse Pay Act of 1989"; and proposed draft legislation to make certain improvements in veterans health-care programs and for other purposes.

H.R. 901

Introduced by yourself, Mr. Chairman, Section 101 of H.R. 901 would amend Section 4118 of Title 38, USC, to provide:

*special pay for nurses employed on a full-time, as well as part-time basis;

*incentive special pay, in addition to primary special pay, based on tenure of service.

Section 102 purposes amending Section 4107(e) of Title 38, USC, authorizing premium pay for Licensed Practical Nurses, Vocational Nurses and Nurse Assistants.

Mr. Chairman, Section 103(a) seeks to amend Section 4108 Title 38, USC, removing certain limitations of employment outside DVA by an employee who was appointed under the provisions of Title 5, USC, and paid under the provisions of Title 38, USC. Additionally, Section 103(b) would provide that no reductions shall be made from the salary of DVA nurses who are eligible for military retirement pay.

Section 104 would amend Section 4106 of Title 38, USC, permitting the appointment of certain qualified individuals in health care positions without regard to certain requirements otherwise applicable to competitive civil service.

Mr. Chairman, in our opinion, each of these provisions can only serve to assist the Department in their efforts of employ health care personnel that have been identified as difficult to recruit and retain. Therefore, the DAV has no objection to the favorable consideration of any provision accomplishing such a goal and we are certainly eager to work with the Subcommittee toward that end.

The DAV supports Section 201 extending, for three years -- until September 30, 1992 -- the State Home Grant Program, as well as making permanent the Respite Care Program.

As we understand it, Mr. Chairman Section 202 would authorize the sale -- for an amount not less than 75% of the fair market value -- of difficult to sell foreclosed properties to certain nonprofit organizations to use as transitional housing assisting homeless veterans who are participants in the Compensated Work Therapy Program.

The DAV is concerned, as I am sure you are Mr. Chairman, with the difficulties and challenges now facing the Loan Guarantee Program. In this regard, we are concerned that the Department make every effort and utilize all possible means to dispose of properties in a manner which will benefit the Government and veterans while not further compromising the integrity of the Loan Guaranty Program.

Additionally, a number of questions arise regarding issues such as liability and supervision by the Government and/or the identified organizations that may choose to acquire such dwellings.

Mr. Chairman, while the DAV has no official position relating to this provision we are interested in learning of the answers to the many questions involved. Additionally, we would suggest if this measure receives favorable consideration by the Subcommittee, implementation be accomplished in a cautious manner. In our view, the most favorable way to achieve this would be via the creation of a pilot program.

We have no objection to expanding the VA's authority to enter into contracts with Federal agencies under the Compensated Work Therapy Program as proposed by Section 203.

Section 301 proposes the establishment of a pilot program for an improved, automated management system for billing and collection of fees charged to third party payers. Additionally, a mechanism would be created whereby the Department would retain a percentage of funds collected to be used for specified purposes.

Although the DAV has no official position regarding Section 301 we would not generally object to its receiving favorable consideration.

Mr. Chairman, the DAV strongly supports Section 302, extending eligibility to dependents of Department of Defense beneficiaries to receive health care services, on a space available basis, in VA medical facilities which have active VA/DoD sharing agreements.

As you are aware, Mr. Chairman, the DAV has proposed and strongly advocates enhanced sharing capabilities between VA and DoD. It is our belief that the creation of a Health Care Alliance between these two Federal Departments would allow both to make the best use of scarce medical resources resulting in ongoing cost avoidances, while providing quality medical care to the largest number of entitled beneficiaries possible.

We agree with the goal envisioned in Section 303, obtaining an accurate and complete list of eligible individuals for participation in CHAMPVA and would not object to its favorable consideration.

Finally, Mr. Chairman, Section 304 would prohibit the contracting out of services in the Veteran's Canteen Service under the provisions of OMB Circular A-76. In keeping with DAV Resolution No. 039 we are supportive of this provision.

H.R. 1199

Introduced by the distinguished and active member of this Subcommittee, Mr. Kennedy, H.R. 1199, the "Veterans Nurse Pay Act of 1989", among other things, proposes;

*condensing from the current 8 to 4 the number of pay grades for VA nurses;

*dividing into 20 equal increments -- called steps -- Title 38 nurse pay grades;

*authorizing an increase in nurses salary by one step every two years for satisfactory performance;

*authorizing the Director of a VA medical facility to provide a salary increase based on certain defined criteria;

*authorizing flexibility to the Director of a VA medical facility in the hiring and salary paid to nurses without prior approval of the Secretary; and

*permitting nurses to be paid one and one-half times their hourly rate of pay for overtime work.

Mr. Chairman, as indicated previously, the DAV is supportive of any action that would achieve the goal of assisting the VA in their efforts to recruit and retain qualified nurses. H.R. 1199 is constructed in such a fashion particularly, we believe, in the context of providing some degree of flexibility to the Medical Center Director. We are appreciative of your efforts, Mr. Chairman, as well as those of Mr. Kennedy in attempting to reach the common goal of improving the VA's ability to recruit and retain nurses and the DAV remains willing to work with the Subcommittee toward that end.

Draft Legislation

Section 1 of the draft legislation proposes the rescission of VA regulation -- Code of Federal Regulations (CFR) 17.51(a) -- relating to extensions of community nursing home care contracts beyond the period of six months.

This regulation provides that any contract extension beyond six months of community nursing home care, at VA expense, not exceed forty-five days. Such a constraint represents a significant departure from previous regulatory authority which provided broad flexibility in decisions to grant an extension based on the individual veteran's particular circumstances.

Mr. Chairman, the question of the VA's policy toward the long-term needs of disabled veterans has been of continuous concern to the DAV. The promulgation of this regulation simply sends yet another signal that the VA lacks a meaningful policy that will substantially address the long-term care needs of a rapidly aging veteran population. Therefore, we would not oppose favorable action of this provision.

Mr. Chairman, Section 3 proposes, in part, that the Secretary, not later than February 1 of each year, be required to submit a report to the Veterans Affairs Committees on the delays in the furnishing of prosthetic services which occurred during the preceding fiscal year.

The DAV wholeheartedly endorses this provision. For the last eight years the DAV has been engaged in an active and ongoing dialog with VA regarding the Prosthetic and Sensory Aids Service, as well as research efforts relating to prosthetic devices.

Spaning this time frame we have witnessed positive changes regarding the manner in which prosthetic services have been administered and delivered to this most deserving and disabled category of veterans. Regrettably, more needs to be done.

We refer specifically to the manner in which prosthetic limbs and devices are delivered, or in many cases not delivered, in a timely fashion to disabled veterans.

During Fiscal Year 1987 the number of prosthetic orders backlogged, for lack of funding, totalled 5,188. At the end of Fiscal Year 1988 that number had risen to 7,552, approximately a 45% increase.

Less than six months ago a Task Force -- comprised entirely of VA employees -- released their report of findings and recommendations.

Their findings were clear and convincing that something must be done to correct a situation that is clearly becoming grossly intolerable:

1. A shortfall of $10.6 million in FY 89 can be expected.

2. An additional 83 FTEE are required for marginally acceptable field operations.

3. 21 VAMCs, without a prosthetic service, were clearly shown to have a documented need for the establishment of such a service.

Mr. Chairman, all indications are that the situation will not improve. Conversely, we sense the situation will worsen considerably over the remainder of this fiscal year and into the future.

In this regard we believe Section 3 is indeed most timely and strongly urge the Subcommittee's favorable consideration.

Mr. Chairman, this concludes my testimony and I would be pleased to respond to any questions you or members of the Subcommittee may have.

Statement of

The American Legion

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WASHINGTON, D. C. 20006

by

SAMUEL J. WALSH, ASSISTANT DIRECTOR
NATIONAL LEGISLATIVE COMMISSION
THE AMERICAN LEGION

and

JOHN F. SOMMER, DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION

before the

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
VETERANS AFFAIRS COMMITTEE
U.S. HOUSE OF REPRESENTATIVES

on

VARIOUS VETERANS HEALTH CARE INITIATIVES

APRIL 12, 1989

STATEMENT OF JOHN F. SOMMER, JR., DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
UNITED STATES HOUSE OF REPRESENTATIVES
APRIL 12, 1989

Mr. Chairman and Members of the Subcommittee:

The American Legion appreciates the opportunity to present its views on the several legislative proposals scheduled for consideration today, all of which relate to the Department of Veterans Affairs medical care system.

Recruitment and retention of health care personnel by the Department of Veterans Affairs is a problem which begs for a permanent resolution if the Department is to continue its mission of providing quality health care and medical services for the nation's eligible veterans. Numerous hearings over the past decade or more have led to stopgap measures which have offered temporary solutions to chronic recruitment and retention problems. Some of the problems relate to nationwide shortages and others to geographic inadequacies of VA pay scales as compared to identical positions in the private sector. In some areas the existing problems relate to a combination of the two.

Mr. Chairman, we are pleased to note that a Health Care Staff Development and Retention Office has been established, as a result of a recommendation set forth by the Task Force on Recruitment and Retention of Non-Physician Health Care Workers in late 1987. The office is charged with developing methods by which to attract and retain non-physician health care professionals in all disciplines.

We are also aware that the Department of Veterans Affairs faces a variety of recruitment and retention issues relating specifically to physicians, many of which are troublesome. Some of these issues relate a great deal to geography, demography, logistics and whether or not a medical center is affiliated with a university.

Rural, secondary medical centers are often located in geographically isolated locations. As a result of this and for other reasons, they have no medical school affiliations or if they do they are quite limited. Consequently, many times there is no residency program in the medical center and senior physicians are required to provide off-duty (medical officer of the day) coverage. In addition, there are usually limited research opportunities if there are any, and the treatment capabilities are such that support services and specialty consultations are limited. As a result, sicker patients are often transferred to tertiary medical centers.

We are told that in this setting it is often difficult to attract board-certified physicians for basic care, much less specialty care. Unless there is a retiring physician in the area, or a doctor has a vested interest in living in the given locale, recruitment can be very difficult.

Affiliated, tertiary medical centers typically seek physicians who are oriented in academia and research to meet the needs of both the VA medical center and the medical school affiliate. Often, finding the desired quality of candidate is more of an issue than finding available candidates. We are advised that when recruitment problems exist in these facilities, they are often in specialty areas where remuneration in the private sector is drastically higher than the VA salary scale. Prime examples are radiologists, orthopedists, anesthesiologists and psychiatrists.

There are several factors that are deserving of mention at this time. For instance, increasingly comments are received by our Field Representatives and others involved with the medical centers that the VA pay scale is not keeping pace with the national average (university and private sector hospitals). Moreover, at many affiliated medical centers physicians are attracted mainly because of the combined VA and university pay. In some instances, starting residents can command salaries above the Chief's level in the Department of Veterans Affairs. We are advised that graduate anesthesiologists can earn $140,000 while the top VA salary is around $85,000.

A major recruitment tool is the research program that is conducted within the Department of Veterans Affairs. However, we are advised that based on the current funding of the research programs, it has become increasingly difficult to gain project funding within the merit review program. We were somewhat pleased to note that in the appropriations for the VA for Fiscal Year 1989, $210.2 million is included for medical and prosthetic research which is an increase of slightly over $17 million from the FY 1988 appropriation. Of course, the research program is a victim of several years of decremental funding as are all of the programs operated under the Veterans Health Services and Research Administration. Inflation is growing at a more rapid pace than dollars. In addition, there are add-on costs, the most significant of which is salary dollars which, we understand, are 70% of the budget. The net result is a tightening of funds for research projects. We understand that in the midst of increasing requests for research funding, the approval rate has been lowered from 58% to about 39%.

The third factor relating to the ability to recruit and retain physicians is the working environment. Many times there is a great deal of frustration within the system regarding clerical support, the rigors of dealing with a bureaucracy, and the funding support and mechanism for equipment acquisition and replacement.

Based on our involvement with the VA medical care system, it is our feeling that the health care specialties in which physicians will be increasingly needed in the system in future years cover the spectrum of the aging phenomena of America's veterans, and specialists in areas such as AIDS and Post-Traumatic Stress Disorder. While these categories cannot be considered to be exclusive, they are the disciplines which are the most prominent.

The Department of Veterans Affairs is in the process of developing an extensive array of services for the aging veteran. Unfortunately, the percentage of VA physicians possessing board certification in gerontology is small in comparison to the demand. We understand that this is a problem in the private sector also, however, as medical school affiliates continue to modestly expand the residency training programs in the field of geriatrics, the VA must prioritize resources to meet its needs in this area. The further expansion of the VA's geriatric research, education and clinical centers (GRECCs) will promote the recognition of the role of geriatric medicine in today's society to a certain extent.

The provision of mental health care by trained psychiatrists or psychologists for the treatment of Post-Traumatic Stress Disorder will continue to be a high priority. Additionally, the specialization in treatment and research of AIDS, dementia and a host of related aging diseases will all require the careful attention of VA health care planners.

The American Legion has stated during a number of presentations recently that the government must provide necessary funding to maintain and improve this system and specifically to maintain adequate compensation levels to attract and retain the highest quality professional staff, and to provide funding for renovation and replacement of aging and inadequate facilities. It has been further stated that the current status of the VA system has been achieved in many ways, but they can be categorized under the headings of treatment, teaching and research — the triad which enables VA to offer veteran patients the full range of technology and procedures now available in the practice of the healing arts. As we have said the three principal elements required to maintain this tremendous undertaking are a continued commitment by the government, recruitment and retention of skilled personnel and the provision of adequate facilities and equipment.

Mr. Chairman, we shall now address the legislative proposals that are currently under consideration of the Subcommittee.

Because of the fact that Title I of H.R. 901 - "Veterans' Health Care Programs Amendments of 1989", and H.R. 1199 - "Veterans Nurse Pay Act of 1989", relate to the same issue we shall, with the Chairman's permission, address those provisions concurrently.

Section 101 of H.R. 901 would amend section 4118 of title 38, United States Code, so as to provide for the authorization of special pay to nurses, in addition to the physicians and dentists who currently qualify under this section. The purpose of the special pay provisions is to provide additional tools to the Secretary in order to recruit and retain highly qualified health care professionals in the Veterans Health Services and Research Administration. There are several different criteria used in the determination of eligibility for the special pay, including tenure, critical nursing specialties which are determined to present extraordinary difficulties in recruitment or retention, service in a specific geographic location, service in a specific position such as head nurse, etc.

Section 102 of this bill would amend section 4107(e) so as to provide special additional pay, or premium pay, for licensed practical or vocational nurses and nurse assistants.

H.R. 1199 takes a different approach to improve recruitment and retention of nurses by providing flexibility in the pay system.

Section 2 of this measure would restructure the nurse grade levels of the Department of Veterans Affairs for nurses employed under title 38, to be consistent with current nurse grades under the General Schedule as set forth in title 5, United States Code. Those grade levels would be as follows:

Nurse Grades	GS Grades
Entry grade	GS 6-10
Intermediate grade	GS 9-12
Senior grade	GS 12-14
Director grade	GS 14-16

The range of basic pay for each nurse grade would be divided into 20 equal steps, and rates of pay within a grade would be established only as full steps. There are currently only 10 steps within a grade.

Regulations which would be prescribed under this section if enacted would provide that the rate of basic pay of each nurse of the Department, employed under Section 4101(1) of title 38, shall be increased at least a one step increment in that nurse's grade not less often than every two years that the nurse holds the grade, unless it is determined that the performance of the nurse during the preceding two years has not been satisfactory. Additionally, whenever a nurse is given a new duty assignment which is a promotion, the rate of basic pay of that nurse would be increased at least one step in the nurse's grade.

An individual serving in a head nurse position would receive basic pay at a rate two steps above the rate that would otherwise be applicable.

Under regulations which the Secretary would prescribe for the administration of the new section, the director of a medical center would be authorized to provide step promotions within a grade, or pay a cash bonus, to a nurse employed at the medical center who has qualifications, experience, or achievement which the director determines exceed the standards for the nurse's grade. In making such determinations consideration would be given to service with relevant professional committees or groups, service in a responsible office in a professional nursing society, educational attainment, publication of articles in professional journals, exemplary job performance, and other appropriate evidence of professional stature.

Additional regulations would provide that a medical center director, when employing a nurse, could appoint the nurse at a rate of basic pay in excess of the minimum rate applicable to the grade in which the appointment is made, without a requirement for prior approval at any higher level of authority if it is determined that it is necessary to do so in order to obtain the services of nurses in that grade at the medical center. Such determinations would be made by the director only in order to provide pay in an amount competitive with the amount of the same type of pay provided nurses at non-Federal facilities in the same labor market, to achieve adequate staffing at the medical center concerned, or to recruit nurses with specialized skills, particularly those which are especially difficult or demanding. Provisions are included for the director's justification for such decisions.

Mr. Chairman, the amendments set forth in both Title I of H.R. 901, and H.R. 1199 are certainly commendable and demonstrate both a need for improvement in the ability of VA to recruit and retain nurses, and a commitment on the part of the authors of the bills to initiate the needed improvements.

The American Legion has an explicit mandate on this issue set forth in Resolution No. 320, approved by the Delegates to the 1988 National Convention. The resolution calls on the Secretary of Veterans Affairs and the Congress to approve increased salary levels for nurses in VA medical centers, so as to be competitive with the private sector.

The provisions included under section 101 of H.R. 901 basically add nurses to the existing special pay provisions currently authorized for physicians and dentists. Unfortunately, we are aware that there are some problems which exist under this system, with the surveys that must be taken before a proposal is submitted to Washington, and the length of time involved in the decision-making process once the request arrives at Central Office. Reportedly there is a great deal of frustration on the part of medical center officials related to the delays that are inherently built into this process.

The provisions of H.R. 1199 appear to provide greater latitude to the medical center directors to immediately establish competitive wages for nurses without becoming involved in a morass of bureaucratic inertia such as that which is reported to exist under the current program.

We strongly support the amendment set forth under section 102 of H.R. 901, which would authorize the provision of premium pay for licensed practical or vocational nurses and nurse assistants. This would certainly assist in alleviating some of the difficulties that exist in hiring and retaining individuals in these critical positions.

Mr. Chairman, several months ago it was reported that there were approximately 3,500 vacancies in the nursing cadre of the VA. Since until recently there has been no end in sight for the funding deficiencies in the VA medical care system, that number is probably even higher today.

The American Legion is aware that the problem is much larger than the Department of Veterans Affairs, or the entire Federal Government for that matter. Nursing just does not seem to appeal to near the number of individuals that it once did, thus drastic shortages exist in the entire career field.

We are hopeful that a package consisting of the recently reinvigorated nurse scholarship program, and the tuition reimbursement, combined with a salary and benefit improvement plan drawn from the legislation under consideration today, and administrative recommendations within the agency, will provide VA with the ability to be competitive with the private sector, in order to be better able to recruit and retain qualified nurses for employment in the medical centers.

Title II of H.R. 901 relates to Health Program Amendments.

Section 201 would repeal the expiration date of the Respite Care program under section 620; and would extend the State Home grant authority under section 5033 of the title by an additional three years to September 30, 1992.

The American Legion is totally supportive of both these provisions.

Title III - Health Care Management.

Section 301 of H.R. 901 calls for the creation of a pilot program for the establishment of "an improved system for the administration of fees and other amounts payable to the United States arising from programs administered by the Veterans Health Services and Research Administration under the provisions of title 38, United States Code." The pilot program would be carried out in one medical region during fiscal years 1990 and 1991. The automated program would have the capability to process fees charged to third parties and to government and private agencies which have sharing agreements with the Department of Veterans Affairs; amounts recoverable by the United States under section 629 of title 38, and; amounts payable as first-party medical copayments authorized under title 38.

Included in these amounts are the payments from insurance companies to VA in the form of third party reimbursement for treatment of nonservice-connected veterans and the copayments and deductibles relating to the means test that are assessed against veterans who have been designated as "Category C."

In developing the automated billing process, VA would be authorized to use "billing and collection expertise and services of the private sector."

The costs of administering the program, including the costs of any contracts, are to be defrayed from amounts received by VA through the program. The remaining amounts are to be allocated as follows:

(1) 25 percent shall be covered into the Treasury as miscellaneous receipts.

(2) 25 percent shall be allocated to funds and accounts of the medical center through which the amounts were collected.

(3) 50 percent shall be allocated to funds and accounts available to the Chief Medical Director.

The amounts retained by the Department of Veterans Affairs are to be used for pay and other personnel benefits to enhance the recruitment and retention of health care employees; or to supplement the medical equipment accounts of medical centers at which such accounts are deficient.

Appropriations language is included in the proposal wherein $500,000 would be authorized to be appropriated to carry out the pilot program.

Mr. Chairman, The American Legion is certainly not generally opposed to automation within the Department of Veterans Affairs. However, there is a major point which we find troublesome with respect to the pilot program set forth in this proposal.

The primary issue is the fact that The American Legion continues to oppose the means test and third party reimbursement as they apply to VA medical care. The Delegates to the 1988 National Convention adopted Resolution No. 278, which resolves that The American Legion support amendatory legislation to Public Law 99-272 and Title XIX of the Act that shall retain the entitlement provisions of the Act while eliminating the requirements for the means test and third party reimbursement. To support a method by which to collect monies emanating from these reimbursement provisions of PL 99-272 would fly in the face of our mandate. For that reason, we do not support this proposal.

Section 302 of H.R. 901 relates to eligibility of military dependents for health care under sharing agreements. The section would amend section 5011(g)(5) to include dependents of members or former members of the Armed Forces who are eligible for treatment through the Department of Defense as "primary beneficiaries" in those instances where there are sharing agreements between VA and DOD medical facilities.

Mr. Chairman, The American Legion has in the past supported certain individual cases of resource sharing between VA and various DOD medical facilities, providing they maintain separate identities for the purpose of carrying out their separate missions. However, there is now a move afoot to cross the line between "resource sharing" and "merger of health care facilities."

With respect to the instant legislation, our interpretation is that active military and retiree dependents would be considered as beneficiaries of VA medical care in those facilities where resource sharing exists. The Legion cannot support the provision of medical care to non-veteran dependents when we now have almost all Category B and C veterans and some nonservice-connected veterans in Category A being denied care in VA facilities.

In looking at the larger picture, The American Legion feels that the Department of Veterans Affairs should maintain autonomy when it comes to delivering health care to veterans.

Military medical facilities and VA medical centers have divergent constituencies with medical needs best addressed by a continued separation of operation. We will continue to support a kind of sharing arrangement, providing VA and the military medical facilities maintain separate identities so that they can carry out their separate missions.

The Legion will continue to support the Department of Veterans Affairs as the sole agency responsible for the administration of benefits and medical care to the nation's veterans. We will, likewise, continue to oppose any efforts to "streamline" VA's medical care system or other programs for the purpose of satisfying a need to find cost savings.

This position is in conformance with Resolution No. 250 approved by the Delegates to the 1988 National Convention, which mandates us to oppose those reorganization plans that would transfer from the Department of Veterans Affairs sole jurisdiction of any veterans benefits and service programs, including medical care.

Section 303 of this bill relates to the CHAMPVA Program.

First, it calls upon the Secretary to compile an accurate and complete list of individuals eligible for the program as of October 1, 1989, and to maintain and update the list thereafter. Medical care benefits provided under section 613 of title 38 would only be paid to those eligible survivors and dependents of veterans whose names are included on the list.

The Secretary would be charged, not later than October 1, 1989, with establishing a procedure for the periodic review of the need for, the cost effectiveness of, and the appropriateness of the provision of health care under section 613 of the title.

Not later than December 1, 1989 the Inspector General would be required to submit to the Committees on Veterans Affairs a report on the compliance of VA with the development of the list of beneficiaries, and the program review.

Under this section the Secretary would also be directed to carry out a study of alternative methods for providing for the costs of health care under the CHAMPVA Program. In carrying out the study, methods are to be considered which would result in a substantially unchanged cost to the United States while providing improved health benefits at lower costs to beneficiaries. Appropriation language is included which would authorize the sum of $500,000 to carry out this study.

The American Legion is aware of the fact that a number of problems exist within the CHAMPVA Program, as highlighted in our statement before the Subcommittee on Oversight and Investigations in March of last year. Therefore, we are supportive of the studies and other provisions set forth in this proposal.

Section 304 relates to the Canteen Service. It would amend section 4203 of title 38 by adding a new subsection which would, as we understand it, prohibit contracting out of the Canteen Service in VA medical centers.

The American Legion is totally supportive of the prohibition of contracting out of the activities of the Canteen Service.

Section 1 of the Draft Legislation we have been asked to review applys to the recision of a regulation relating to the use of community nursing homes. The regulation, 38 CFR 17.51a was amended to restrict the length of time that an extension of nursing home care beyond six months in a contract public or private nursing home facility may be authorized to a maximum of 45 days. In addition, the amendment considerably narrowed the criteria under which an extension may be made. These final rules were published in the Federal Register on April 21, 1988.

The American Legion fully supports the recision of the amendment to this regulation, which would restore the provisions of the regulation as they currently existed. Unfortunately, according to a recent survey of medical center directors that was carried out by The American Legion, one of the programs that has been hardest hit by the funding shortfall in VA medical care is the contract nursing home care program. Seventy-one percent of the medical centers reported severe reductions in funding to support this program. Of those, twenty directors reported that they are providing less than three month contracts and twelve reported that no community contracts are being provided to nonservice-connected veterans. They must obtain community nursing care at their own expense. In addition to the reduction in the length of the contracts, forty-five medical centers reported a reduction in the average number of veterans included in the program.

Section 2 of the Draft Legislation pertains to the submission to Congress of reports of the Geriatrics and Gerontology Advisory Committee. The amendments to section 4101(f)(2) set forth in this section basically update the language contained therein, streamline the reporting mechanism of the Committee, and reduce the number of days after receipt of a report from the Committee that the Secretary shall submit to the Congress such report and comments and recommendations thereon from ninety to thirty days.

The American Legion supports the amendments set forth in this section. The responsibility of the Geriatrics and Gerontology Advisory Committee is great and the Committee's work is important in consideration of the impact that the aging veteran population will have on the Department of Veterans Affairs. The Department should be a leader in geriatric health care and the input and recommendations of the GGAC are necessary for that to be accomplished.

Section 3 of the Draft Bill relates to the provision of prosthetic appliances. It amends section 614(a) by clarifying the language, and by adding a new paragraph relating to an annual report on delays in ordering prosthetic services. This provision would require that not later than February 1 of each year, the Secretary shall submit to the Committees on Veterans Affairs a report on delays in the furnishing of prosthetic services which occurred during the preceding fiscal year. Each report is to set forth (1) the number, and the location, of medical facilities at which orders for such services were held more than five days; (2) the number of such orders that were held more than five days; (3) the average length of time such orders were held at each such facility; (4) the total dollar amount of orders held for more than five days; and (5) the reasons for the delays in placing such orders.

The American Legion is fully supportive of the proposal set forth in this section. In numerous instances over the past several years, site visits by our Field Representatives have found delays in the ordering of prosthetic devices. These delays have been primarily the result of shortages in prosthetic funding at the medical center level. We have found that at times prosthetic orders are delayed from quarter to quarter so that funding can catch up with the demand. We trust that the reporting mechanism set forth in this provision would help identify and eliminate the root of this problem.

Mr. Chairman, that concludes our statement.

Statement of
Claudette Morrissey, RNC
President
Nurses Organization of the Veteran's Administration

Before the
U.S. House Committee on Veteran's Affairs'
Subcommittee on Hospitals and Health Care

April 12, 1989

Mr. Chairman and Members of the Subcommittee, I am Claudette Morrissey a Registered nurse employed full-time as a Staff Nurse on the evening shift in a surgical intensive care step-down unit at the Veterans Administration Medical Center, Brooklyn New York. I am here today speaking as the President of the Nurses Organization of the Veterans Administration (NOVA). I am accompanied today by NOVA's Legislative Director Noreen Sommer a Registered Nurse employed full time as a Community Health Nurse in the field of Spinal Cord Injury and Comprehensive Rehabilitation at the VA Medical Center Palo Alto, California. NOVA thanks you Mr. Chairman for your long history of commitment to our nations veterans and the veteran health care system established to serve them. NOVA is speaking today for the nurses who continue to stay and care for veteran patients in spite of staff shortages, budget shortfalls, and difficulties recruiting and retaining health care personnel. We are loyal and dedicated employees who pull together in difficult times, who like taking pride in what we do and dislike seeing the VA attacked and criticized from without. We are resentful when non-VA nursing colleagues indicate they think the VA is a second class place to work or assume that if you can't work elsewhere you can always work at the VA. We have glimpses from time to time of how great the VA health care system can be and take pride in the system's accomplishments. On behalf of these nurses I wish to thank you Mr. Chairman for having heard us when we appeared before you in the past. We commend you on your untiring struggle to obtain adequate appropriations for our mission to provide quality care to veterans. When NOVA polled nurses last July, 83% of the respondents answered that there were insufficient resources to recruit and retain nurses at their hospitals. It was clear from their responses that inadequate funding was at the heart of the problem. Nurses are aware of the realities of budget constraints and as the pressure has built to treat sicker patients in a more rapid time frame nurses have done their part. We have tried to prepare patients and families for earlier discharge. We have been a part of innovative non-institutional solutions such as Respite Programs, Adult Day Health Programs, Hospice and Hospital Based Home Care and increased utilization of community resources. The VA can no longer try to meet the budget targets by making unreasonable demands of nurses and breaking its covenant with sick and needy veterans to provide medical care. This care can be provided only when the VA is able to recruit and retain adequate numbers of Registered Nurses and other health care personnel. The difficulty recruiting and retaining qualified nurses is at the center of the challenge to provide appropriate care at the VA medical centers.

NOVA's poll confirmed the finding of the 1986 VA survey of field facilities which reported budget reductions were cited for more than half the loss of registered nurses. The gloomy budget picture has not been relieved in the past year. NOVA has attempted to illuminate the problems and has offered recommendations for solutions in the past so we will not go into great detail today. Simply stated there is a national shortage of nurses. The VA is not competitive in salaries, benefits and working conditions to compete in the free market for this scarce human resource. To compound and confound this further the budgets at many facilities are so strained that when nursing positions are vacant because of recruitment difficulties the empty nursing slots are sacrificed and the ceiling is reduced or frozen at a lower number, making the situation for the nurses remaining unbearable. The problems are not identical in every hospital. Some report they have not had a new graduate apply for a position in over two years and others report they can recruit only new graduates who work less than one year and then move on. Many hospitals can find nurses available but due to a shortage of funds there is a hiring freeze and some hospitals report they have resources but can't find nurses. It is not uncommon to take 90 to 120 days to fill vacant positions. The workload for the nurses who remain increases with each unfilled vacancy. This heavy workload affects recruitment because nurses frequently inquire about the nurse to patient ratio when they apply for work and decline employment when they hear the answer.

Mr. Chairman we appreciate the outstanding efforts of you and your committee in supporting solutions to the present nursing shortage within the VA medical care system. Last year NOVA was pleased to support the legislation originating in this committee that attempted to stop the hemorrhage of nurses from the system by implementing bonuses for tenure, full time work, head nurses and for highly qualified nurses with specialty certification. Our caution then as now is that discretionary bonuses without adequate funding do not get used. As we stated then we believed that the solution to maintaining salaries comparable to community rates rested in a revision of the basic pay rates for all VA registered nurse. It was our belief then and continues to be NOVA's belief that discretionary bonuses on top of inadequate base salaries are a necessary but only a short term remedy and that raising the denominator of base salaries is a necessity. It is for this reason that our members were pleased to see that HR 1199 has so many of the elements that have been shown to be important approaches to overcoming the historic financial compensation disincentives in the nursing profession. It has built upon the strength of the current VA nurse pay schedule which rewards experience, education, and performance. It is consistent with the recommendations of the Secretary of Health and Human Services Commission on Nursing which included a recommendation to expand nurses pay ranges and have pay scales reflect different levels of experience, performance, and education. While it does not automatically increase nurse salaries across the board it does allow for increased flexibility in initial appointment and expands the opportunity for pay advancement throughout a nursing career. Having given the authority to the hospital administrator to respond to the needs of the local labor market, which is driven by a variety of factors such as the local cost of living it is our understanding that this legislation will continue to allow for the use of special salary rates in excess of the maximum rate in those truly special instances in which the maximum rate is not competitive with the local community. We believe that this will restore the meaning of special to *special rate* rather than having it be the standard as it is now. As NOVA has testified in the past special rates have been administratively cumbersome to implement and thus caused delays in responding to the rapidly changing environment. Many nurses have left the VA for higher paying community hospitals while a VA hospital waited for approval of special salary rates from Washington. By institutionalizing a pay scale that more accurately reflects reality it should help Medical Center Directors more accurately project salary costs, and reduce the administrative costs associated with a widespread special salary rate program. When 120 of the 172 VA medical centers are using special salary rates they are hardly special.

Section 3 of HR 1199 includes some long awaited recognition for VA head nurses with the inclusion of an increase of two salary steps while they serve in that position. Our only concern is how these and other steps for outstanding service and achievement will be handled for nurses who have reached the last step of their grade and have not obtained the qualifications for the next grade.

Nova was gratified to hear that the issue of the overtime pay cap would be addressed in this legislation. The issue of the cap on the overtime rate is one that our members have brought to our attention frequently because it seems to defy their belief in common sense and fair play. The situation they describe is as follows. It is not uncommon for a nurse to be asked to work a second shift in one day and earn less per hour for that second overtime shift than the original scheduled shift. The overtime rate is currently limited.in the following way. A nurse is paid the overtime rate of 1.5x the usual hourly rate of pay until the maximum of $20 per hour is reached. Thus a nurse who is full grade step 5 receives 1.5x the hourly rate. This percentage is gradually reduced for each step thereafter until Senior grade step 7 where the nurse would in fact make less at the overtime rate than the senior grade step 7 regular rate. This situation is made worse in areas with special salary rates. In the San

Francisco Bay Area special salary rates create a situation where Intermediate grade nurses step 4 and above will in fact make less at the overtime rate than their basic rate of pay.

The resulting situation is that the overtime rate is so unfair that nurses resist working overtime and are instead frequently given compensetory time off, 1 hour off for 1 hour of overtime worked. This process conceals the amount of overtime that is needed to staff the hospitals and contributes to a continual shortage of staff available to care for patients if nurses take the comp time to which they are entitled.

Support Services

Nursing is not the only area where there have been staff cuts and shortages. There are shortages in other departments and nurses are required to fill in the gaps as respiratory therapists, blood drawers, ward secretaries and housekeepers. Systems intended to increase efficiency and accuracy such as unit-dose medication are compromised when pharmacy is short staffed and pours 2 or 3 days of medication on the unit dose cart. The burden to adjust falls on the shoulders of nurses. When nurses are used as the all-purpose disposable employee, patients are deprived of nursing care and nurses get used up. VA nurses in their responses to studies over the past 20 years have identified inadequate support services as a major problem. The HHS Secretary's Commission on Nursing and the VA's own Task Force on Recruitment and Retention recognized the need for increased non-clinical support services 24 hours 7 days per week as well as staffing of clinical service departments to provide care in off-hours so that professional nurses will be free to care for patients.

Patient Care

From the perspective of the health professionals working on the front lines the budget cuts, staff shortages and workload adjustments of the past are having an impact now. There are not sufficient numbers of VA nurses to fulfill the VA mission of quality care. The ability to provide patient care is severely compromised when there are not enough nurses. Nurses tell us the numbers just do not add up. It is common that the number of hours of patient care needed far exceeds the number of staff hours available to provide the care. When this happens patients do not get the care they require. Nurses experiencing this excessive workload are working so fast that we fear we will make a serious life-threatening mistake or that we will not be available to observe when a patient's condition changes for the worse. Many nurses entered nursing for humanitarian and altruistic reasons and are not afraid of hard work. What we do fear is that harm will come to a patient because we are unable to give them the nursing care they need.

NOVA has stated in the past that overworked nurses are poor recruiters for the VA system. Retention of nurses already working needs to be our first concern. A cadre of satisfied, enthusiastic, competent and caring nurses will be our best recruiters for the future.

We ask the support of all the members of this committee to approve the approaches reflected in HR1199 because it is needed to recruit new qualified nurses and it is consistant with the recommendation to improve the long-term career orientation of VA nurses already working at the VA medical centers. Additionally we would ask the assurance of this committee that this legislation will be accompanied by an appropriation request that will make it possible for directors of medical centers to use the pay step flexibility to recognize the outstanding performance and accomplishments of nurses.

The ability of VA to provide care to veterans comparable to and not less than that offered in the private health sector is critically compromised by VA's current nurse patient ratios and inability to recruit and retain adequate numbers of nurses.

NOVA commends this committee for what you have done thus far to improve VA competitiveness and we thank you for the opportunity to appear before you today. We pledge to continue working with Congress and VA to assure that veterans receive the care they need and deserve.

AMERICAN NURSES' ASSOCIATION
WASHINGTON, D.C.

TESTIMONY

OF THE

AMERICAN NURSES' ASSOCIATION

ON

VETERANS' ADMINISTRATION RECRUITMENT AND RETENTION

BEFORE THE

HOUSE VETERANS' AFFAIRS COMMITTEE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

PRESENTED BY

IRENE M. LUSSIER, R.N.

APRIL 12, 1989

1101 14th STREET N.W., SUITE 200, WASHINGTON, D.C. 20005 — 202-789-1800

Mr. Chairman, I am Irene M. Lussier, R.N., a psychiatric staff nurse at the Albany Veterans' Administration (VA) Medical Center. I presently serve as Chairperson of the Nursing Retention Committee, and I am also Chairperson of the New York State Nurses' Association's Council of Nursing Practitioners which represents registered nurses (RNs) in collective bargaining at the Albany Veterans' Administration.

The 188,000 members of the American Nurses' Association (ANA) and its 53 constituent state nurses' associations, appreciate the opportunity to address the recruitment and retention of nurses within the VA. A significant number of ANA members are VA nurses. In addition, ANA has represented VA nurses in collective bargaining since 1967 through its state nurses' associations.

Our message is clear -- all is not well in VA hospitals. In fact, if the VA health care system were a patient, we would describe its condition as "critical." There is no doubt that this condition will deteriorate if meaningful measures are not taken.

This hearing reflects the committee's continued commitment to the provision of quality health care for the men and women veterans of our nation. The committee has been instrumental in improving working conditions for nurses; guaranteeing nurses the right of collective bargaining; encouraging nursing career development; providing educational opportunities; promoting clinical nursing research; and fostering the critical inclusion of nursing within the Veterans' Administration health care system. The committee has also stressed the inclusion of women veterans within the VA programs. Those policies have done much to ensure quality nursing care for all veterans. It is our hope that the committee will continue to address the needs of the patients and health care personnel so that we may improve not only the quality of care rendered to veterans but also access to the health care system.

The nation's hospitals including the VA are facing a critical nursing shortage. This is occurring at the same time the VA is facing an influx of older and sicker patients. These veterans are more seriously ill. Their care is complicated by factors of age, the presence of chronic illnesses affecting many body systems, the use of highly technological treatments, pressures for early discharge, and the rapid increase in the number of patients with acquired immune deficiency syndrome (AIDS).

The needs of patients in today's health care system require the care of RNs. The surging demand for nurses, a major factor in the national nursing shortage, provides evidence that efficient, effective utilization of qualified, experienced RNs is needed to preserve quality of care within the limits of cost containment. Unfortunately, this increased demand occurs during a nursing shortage crisis experienced throughout the public and private health care arena.

Background

Years ago, VA hospitals were in the forefront with respect to nurses' salaries, benefits, and educational and professional development. However, as the private sector responded to changes in reimbursement, patient acuity, and health care manpower concerns, the VA has been unable to compete. The private sector can respond to market demands faster than the VA which is subject to the appropriations process and budget restrictions. Nowhere is that more evident than in nursing recruitment and retention. In Pennsylvania, for example, we are told that VA hospitals have no budget money for recruiting nurses. In fact, the nurses themselves, experiencing the impact of the nursing shortage on their patient care, have funded recruitment events.

We are concerned that where the VA once led the way in research and innovative clinical programs, budget reductions will impede the development of new care approaches. It is especially important that the VA's advances in geriatric care and gerontological research and education not be curtailed. Additionally, as the numbers of aged veterans and those requiring long term care (patients with head injuries and HIV infection) increase, we must have adequate nursing homes and manpower to provide quality health care. Nurses who participate in VA funded research grant programs report an inability to get basic resources such as desks.

As a result of FY 89 budget restrictions, we have already seen veterans' access to health care adversely impacted. Many VAs have closed beds and units due to the inability to supply nurses; other VAs are examining their specific mission which may limit veteran access. Additionally, clinics in Chicago have been told to discharge stable patients and only service-connected patients can be followed indefinitely. Community follow-up is questionable.

Budgetary reductions have also resulted in a reduction in nurse mix in several VA medical centers; in some, a 50 percent correction (staff reduction) has been ordered. Nurses from Illinois and California VA hospitals report freezes in employment of RNs, licensed practical nurses (LPNs), and licensed vocational nurses (LVNs). The Illinois Nurses Association reports that one VA hospital has 20 nurses on waiting lists for hire because the hospital cannot foresee a ceiling for RNs because of budget uncertainties. In Region 6, several hospitals, including Livermore and Reno, reduced their RN ceiling in FY 88 in anticipation of the FY 89 budget restrictions. How can we justify hiring freezes on VA nursing personnel and reductions in nurse mix, when there is an extreme nursing shortage within the system?

The freeze has also meant that in Illinois' Westside clinic, RNs were rotated to the emergency room with no orientation, even though many of them did not have the requisite skills for emergency care duty. Similarly, medical-surgical RNs in the Martinsburg, West Virginia facility have to float to oncology units without sufficient orientation. In one California facility, the position of the infection surveillance coordinator has been reduced to a 0.5 full time employee equivalent (FTEE) level, and the coordinator must share evening administrative nurse on-call duties. This is occurring while private sector infection control practitioners are reporting an increase in their workloads in response to the development, implementation, and compliance with occupational health standards for blood-borne diseases such as hepatitis B and HIV infection.

Nurse managers have been instructed to increase non-RN staff to make up for RN reductions. However, VA medical centers report high LPN/LVN vacancies and turnovers, and reductions in LPN/LVN ceilings. The VA cannot employ adequate numbers of LPNs/LVNs because they cannot compete with the private sector. This decrease in RN mix also means that the VA will have to utilize increasing numbers of lower skilled employees to provide health care to veterans. It may also mean that veterans may be deprived of essential life-preserving care and treatment. In North Chicago, the Illinois Nurses Association reports that if the chemotherapy nurse is on leave or ill, there is no replacement; therefore, no chemotherapy is provided.

The operating room nurses in the Martinsburg's VA are required to float to the medical-surgical units. The Lexington, Kentucky VA has had two nurse anesthetist vacancies for some time. Both these situations may limit scheduling of surgeries for veterans.

The proposed budget will provide no funding for the revision of RN pay scales. As pointed out in the document "The Need is Now", $400 million must be appropriated to maintain the same level of RN staffing in FY 90. Those funds must be provided in full and up front, in order to eliminate the occurrence of serious shortfalls. Previous shortfalls have resulted in staff cutbacks and corresponding reductions in needed services for veterans.

Existing shortfalls will result in a reduction of more than 100 RNs in the northeast region. Those numbers do not include nursing assistants, whose cuts could be equal to or more than the RN cuts. The mid-atlantic region has been instructed to reduce RN ceilings by 76 and LPN/nursing assistants by 25. Those facilities that have not reduced their staff will be required to do so in the future. Additionally, reductions in clerical, pharmacy, and respiratory therapy positions will mean additional duties for RNs.

Nursing staff and support salaries must be increased; at least 3,000 beds are reportedly closed due to nursing shortages. The VAs in Cincinnati, and Louisville and Lexington, Kentucky have hired nurse recruiters to combat the nursing shortage. The VA no longer leads the way with benefits such as salaries or retirement packages. Nor has the VA been able to supply the necessary computer assistance for nursing, as many hospitals in the private sector are doing.

Decreases have occurred in funds for education programs. Nurses across the country complain that they cannot attend continuing education programs because the hospital cannot spare them for a day, even when they personally fund the classes and request annual leave as opposed to administrative leave. VA nurses will not be able to acquire new skills or maintain skills if such practices continue. Additionally, nurses may not be able to meet state licensure requirements for continuing education.

H.R. 1199 - "Veterans Nurse Pay Act of 1989"

ANA has reviewed H.R. 1199, the "Veterans Nurse Pay Act of 1989", sponsored by Representative Joseph Kennedy (D-MA), and endorses the bill. We have stressed the VA's inability to compete with private sector salaries for nurses repeatedly over the years. The national nursing shortage has increased the competitive gap and the report of the Secretary of Health and Human Services Commission on Nursing indicates we cannot expect immediate relief from the shortage. Private sector hospitals have reviewed the Commission's recommendations and some have begun to initiate those recruitment and retention initiatives for nurses.

We believe restructuring of nurse grades is necessary and long overdue to assure adequate qualified nurses to care for veterans who utilize the VA health care system. It is also important that such changes address the long term VA nurse. Since the numbers of those entering nursing have decreased so dramatically, the VA must retain its experienced nurses. We believe that the VA must recognize those nurses who have acquired additional skills and experience as outlined in Section 3 (a) of the bill. However, we must stress that the nursing salary structure, which we would recommend to be even higher is not the only issue with recruitment and retention of nurses. Appropriate support staffing must be provided. Title 5 health care employees provide needed support services, which if inadequate, increase the already overburdened staff nurses. Nursing must then assume those functions of support personnel when inadequate staffing exists, lessening the amount of time that nurses can provide direct nursing care to patients.

H.R. 901 - "Veterans' Health Care Programs Amendments of 1989"

We have also reviewed H.R. 901, the "Veterans' Health Care Programs Amendments of 1989" sponsored by the Chairman, Representative (G.V.) Sonny Montgomery. We would like to point out that VA nurses are not unique in the federal government. Recruitment and retention problems exist for nurses in other federal services such as the Public Health Service, the Indian Health Service, and the Department of Defense. Although all of these are examining the problem and developing and implementing solutions, we believe something must be done immediately. Historically, ANA has supported federal special pay provisions which permit the VA, the Public Health Service, and the National Institutes of Health to compete with the private sector for registered nurses. However, we have become increasingly concerned about the complexity of the programs' implementation and lack of budget allocations for such discretionary pay.

Although we support the intent of Section 101, we are concerned that the special pay provisions and specialty service differentiation may cause morale problems between nursing units. Additionally, the designation of a nursing specialty, if narrowly defined may restrict the utilization of incentive special pay for medical-surgical nurses who are in short supply in some VA hospitals. The specification of specific dollar amounts seems to be outdated and inflexible for future application in light of inflation.

While we recognize that this committee has no jurisdiction over the Office of Personnel Management (OPM) and that VA nurses are under Title 38, OPM has the responsibility of classifying and establishing standards for professional nurses and Title V nursing service personnel and, therefore, patient care in the federal government. We believe OPM could be more effective and responsive to the health care demands of government health care systems, if it employed a nurse at the policy level. Logic would dictate that if classifications and standard policies are being determined for approximately 100,000 nursing service personnel, 64,000 of whom are VA employees, a professional nurse is needed to ensure effective policies that would accentuate the VA. Additionally, we believe heightened and informed awareness by the OPM regarding nurses would affect VA policies as well.

We applaud the provisions in this bill and H.R. 1199 which provide incentives for head nurses. However, we believe they may be insufficient to persuade the experienced qualified VA nurse to accept such a challenging responsible position. The burdens of staffing demands in addition to the administrative responsibilities within the VA will make private sector positions at the same professional level but with competitive remuneration, benefits, resources, and flexibility more attractive.

ANA wholeheartedly supports Section 102 which would treat the LPN and nurse assistant the same as an RN with regards to premium pay. We appreciate your recognition that non-professional nursing support is necessary to provide quality care. We also commend your clarification of outside employment with regards to Title 5 employees. However, the issue remains unresolved for RNs covered by Title 38. ANA believes that Section 103 which also extends compensation of retired military personnel to RNs will indeed make the VA more attractive to experienced nurses.

Recommendations

We believe the VA's ability to provide quality care to veterans comparable to that offered in the private health care sector continues to be severely compromised by the VA's inability to compete with the private sector for the recruitment and retention of nurses. Although this committee and the agency have done much to facilitate VA competitiveness, much more needs to be done and without further delay. We will continue to advocate a change in the restrictive civil service pay schedules.

Conclusion

We must reiterate our statement on the FY 90 VA budget that it is insufficient to meet current services. Future health care worker shortfalls and, therefore, further reductions in health care services will occur in order to meet the demands of an inadequate budget.

We applaud the sponsors of the above mentioned recruitment and retention authorization legislation. However, as we have pointed out in our February 9, testimony on the VA budget before this Committee, the VA medical care program cannot continue to absorb the costs of pay raises and special pay. Congressionally mandated funds for personnel costs must be provided. We cannot continue to rob Peter to pay Paul when neither are adequately funded to meet veterans' health care needs.

We would also like to mention another concern which has been brought to our attention by VA nurses. Staff nurses have expressed the belief that when Congress has legislated past recruitment and retention efforts for VA nurses, e.g., Saturday premium and on-call pay, tuition reimbursement and bonuses, they have been kept in the dark. Although those VA nurses represented by collective bargaining agreements through our state nurses associations have received information about such programs we believe that these beliefs, however mistaken, may be detrimental to personnel morale. The VA must consider timely and effective ways to inform its nurses about recruitment and retention policies. Nurses must not perceive that the information about and implementation of these programs is inequitable or inconsistent because of administrative discretion. ANA, its state associations and specialty nurse organizations such as Nurses of the Veterans' Administration (NOVA) continue to be the effective information resource for the VA nurses regarding professional salaries and benefits within the VA system.

Lastly, and most importantly, we believe that nursing's ability to engage in effective collective bargaining must be maintained throughout the VA. The National Labor Relation Board's (NLRB) recent decision to recognize all RN bargaining units in the private sector means that the VA will have to compete even more vigorously in the provision of meaningful contracts, in addition to salaries and benefits.

We believe collective bargaining impacts health care personnel retention and recruitment within the VA medical system. Collective bargaining provides an effective mechanism for nurses to address practice and economic issues, including clinical practice decisions, orientation for new graduates, professional practice committees, patient classification systems, and staffing levels. Experts agree that wage compression is a serious deterrent to attracting young, career-minded individuals to nursing. Contract negotiations are producing genuine advances in compensation, particularly for experienced nurses. These advances in practice and economics interact to make nursing an increasingly attractive career. Efforts to recruit new candidates and retain experienced nurses have been strengthened by the collective bargaining process in the private sector, the VA must be able to respond accordingly.

ANA and its constituent state nurses' associations have represented VA nurses since the early 1960s. In August 1983, ANA was granted National Consultation Rights at the agency level of the Veterans Administration. In July, the U.S. Court of Appeals for the District of Columbia Circuit ruled that the Veterans Administration administrators' authority to issue regulations concerning the working conditions of Department of Medicine and Surgery employees, including nurses supercedes the employees' rights to engage in bargaining over those conditions. The administrator is not obligated, according to the court, to engage in collective bargaining on any condition of employment on which regulations have been issued. In the case, involving the Colorado Nurses' Association, the VA contended that it was exempt from the obligation to engage in collective bargaining with its nurses because the Department of Medicine and Surgery Statute grants the Administrator the sole authority to determine their conditions of employment "notwithstanding any law." The Colorado Nurses' Association and ANA argued that the Department of Medicine and Surgery's (DM&S) statute should be read in tandem with the Federal Service Labor-Management

Relations' statute which provides that federal employees have the right to engage in collective bargaining with respect to conditions of employment. Nevertheless, in accepting the VA's argument, the court stated, "The purpose of this language is clear: when the Administrator prescribes regulations concerning conditions of employment, he is to be unhampered by the range of federal personnel statutes and regulations that might otherwise constrain his authority."

The court's decision overturns an earlier ruling by the Federal Labor Relations Authority (FLRA). The FLRA had recognized that Title 38, authorizing facility administrators to issue regulations, and Title 5 permitting collective bargaining, were not mutually exclusive. At that time, the FLRA specifically held that a proposal to establish a grievance and arbitration procedure was within the duty to bargain. However, the appeals court reasoned that, because Title 38 does not leave room for mandatory collective bargaining over union proposals relating to working conditions, the VA need not bargain over any of the proposals at issue in the case. The breadth of the current decision calls into question continued collective bargaining rights of VA nurses currently represented by state nurses' associations.

For several years, ANA and state nurses' association have vigorously fought to protect the rights of VA nurses to engage in collective bargaining. The Colorado case represents the consolidation of common issues from cases which also involved the New York State Nurses' Association and the Illinois Nurses' Association.

ANA believes that Congress intended for the VA nurses to have the same rights and protections under collective bargaining that private sector nurses enjoy. Granting collective bargaining to Title 38 employees was essential as a recruitment and retention initiative. ANA therefore, adamantly believes the recent Court of Appeals' ruling will have an adverse impact on the VA's ability to attract health care professionals.

In closing, we reiterate our commitment to assuring quality nursing care to our nation's veterans. As a profession, nursing has always responded to health care crises, and we pledge to work with the VA to provide the nurses necessary to operate the VA health system. We hope that these hearings help maintain the ability of the VA to provide quality health care.

Thank you for the opportunity to address recruitment and retention that affect veterans' health care. We pledge nursing's support in implementing the programs and changes necessary to respond to the present and future health care needs of today's and tomorrow's veterans.

Statement of

NOEL C. WOOSLEY

AMVETS NATIONAL SERVICE DIRECTOR

Before The

U.S. House of Representatives

Committee on Veterans' Affairs

On

H.R. 901 - Veterans' Health-Care Programs Amendments of 1989

H.R. 1199 - Veterans Nurse Pay Act of 1989

9:00 a.m.

Wednesday, April 12, 1989

Room 334, Cannon House Office Building

Mr. Chairman, members of the Committee, AMVETS is pleased to comment on the proposed legislation as outlined in your letter of invitation. We will address each bill in the order we received them (I. H.R. 901, II. H.R. 1199, III. Draft Bill) for discussion during this hearing.

The legislative issues being considered here today, if passed by the Congress, will address some of the areas AMVETS designated as high priority during our last National Convention. We are all aware of the Department of Veteran Affairs' (DVA) health-care staffing shortages and none is more critical than the shortage of qualified nurses. Beds have been closed and services have been reduced as a direct result of the Veterans Health Service and Research Administration's inability to attract and retain the type of individuals needed - no, mandated to perform the nursing duties in the largest medical system in the free world.

Two of the bills before us here today (H.R. 901 and H.R. 1199) will enable the new DVA to better compete with the private sector in recruitment and retention of those so often unsung heros of the medical profession - the nurses. Let's face facts, without an adequate nursing staff medical services cease to exist.

In an effort to emphasize just how important an issue nurses pay and benefits are to the nurses themselves, the following is a list of NOVA Legislative Priorities:

NOVA LEGISLATIVE PRIORITIES

I. Competitive Salary Rates for Nurses

- Revise the base pay rates for Title 38 registered nurses.
- Provide COLA for nurses on special salary rates.
- Provide incentive bonuses for tenure, bonuses for specialty certification.
- Remove the pay cap from overtime pay for registered nurses.
- Implement results of studies on nurse pay: i.e. pay compression and pay differentials for PM's and nights.
- Remove restrictions on additional outside employment.

II. Adequate Support Services

- Resources for application of modern technology to support nursing care, eg. adequate computer resources, unit dose, pharmaceutical delivery.
- Employment of ancillary personnel responsible to nurses to assist in the clinical and non-clinical support tasks essential to nursing care.

III. Adequate Nursing Staff

- Require accountability to VA staffing guidelines to promote quality care and job satisfaction.
- Enhancement of recruitment efforts and adequate budgets.
- Support for nursing education outreach programs.

Mr. Chairman, H.R. 901 as proposed will allow the DVA some of the latitude and flexibility it has long needed to compete in today's market and ensure that the Veterans Health Service and Research Administration will have not only an adequate nursing staff but the best qualified.

Therefore, AMVETS supports Section 101 - Special Pay for Nurses; Section 102 - Premium Pay for Licensed Practical or Vocational Nurses and Nurse Assistants; Section 103 - Clarification of Certain Limitations with Respect to Employment; and, Section 104 - Appointment of Certain Individuals in Health-Care Positions.

Section 201 - Extension of Expiring Programs: The State Home Grant Program should be continued as well as the Respite Care Program, and we support this section of the bill.

Section 202: While we are not adamantly opposed to this section, we have some concerns and reservations in this area. Please understand, we are not sure that passage of this section would create yet another deficit producing program in the already beleaguered Loan Guaranty Program. However, if there is the smallest possibility that a program as outlined in Section 202 could cause further deficit spending or increase DVA's liability in any manner, we would be unable to support this section of H.R. 901.

Section 301: We find nothing in this section that would cause us to oppose it, and therefore would not object to its passage.

Section 302: A review of our national resolutions reveals we have no position/mandate in this area. While we support VA/DoD sharing, when and where it is beneficial; our only concern here would be that "on a space available basis" sounds well and good, however we do not want our veterans finding themselves in line behind military dependents. AMVETS supports this section with the understanding that veterans will not be denied any manner of treatment they are eligible for because the staff or facilities were otherwise occupied in treating military dependents.

Section 303: AMVETS is supportive of the completion of an accurate list of individuals eligible for CHAMPVA.

Section 304: Mr. Chairman, AMVETS is strongly supportive of this section of H.R. 901, which would prohibit the contracting out of services in the Veteran's Canteen Service. We have and will continue to support any measure or proposal that serves to curtail the provisions of OMB Circular A-76.

H.R. 1199: The "Veterans Nurse Pay Act of 1989", as introduced by Mr. Kennedy, is another fine example of the dedication of the members of this committee to resolve the current crisis facing DVA's ability to provide services.

Here again, AMVETS is extremely supportive of any legislation that would serve to alleviate the current shortage of qualified nurses within the Veterans Health Service and Research Administration. Whether the best tool to achieve the goal is H.R. 1199 or H.R. 901, we would hope is not at issue. Perhaps the answer to the current dilemma may be found by incorporating some, or all, of the proposed measures as long as the final outcome will allow the VA to recruit and retain qualified nurses.

AMVETS thanks the members of this committee, especially the Chairman and Mr. Kennedy, for their foresight and concern for America's veterans as expressed in the introduction of these two bills.

DRAFT LEGISLATION

Section 1: AMVETS would not be supportive of this legislative proposal as it is targeted toward reducing care for the long-term disabled as well as the aging veteran.

Section 3: AMVETS enthusiastically supports this provision. We feel very strongly that some type of accountability must be put in place to monitor the Prosthetic and Sensory Aids Service. When a task force of VA employees were directed to review and report on the PSAS, what they found and reported was anything but complimentary. In fact, their findings revealed an overall system-wide situation that is totally unacceptable.

We would hope that favorable consideration of Section 3 will serve to improve the overall operation of Prosthetic and Sensory Aids Service.

Mr. Chairman, this concludes my statement.

Vietnam Veterans of America, Inc
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April 11, 1989

Honorable G.V. (Sonny) Montgomery, Chairman
House Committee on Veterans Affairs
Subcommittee on Hospitals and Health Care
335 Cannon House Office Bldg.
Washington, D.C. 20515

Dear Chairman Montgomery:

This letter is intended to serve as a substitute for appearing at the April 12, 1989 hearing you have scheduled for purposes of receiving testimony on legislation, HR.901 and HR.1199, to offer recruitment and retention incentives for health care personnel within the DVA's health system. We congratulate you and your colleagues on the introduction of each of these measures and look forward to supporting some combination of the two bills as they proceed throughout the legislative process.

As you will recall, the Vietnam Veterans of America, Inc. (VVA) has testified before each of the Veterans Affairs Committees and before the Human Resources Task Force of the House Budget Committee to the effect that among the numerous problems besetting the DVA health care system, the problem of health care staff shortages should be meaningfully resolved. Each of these two measures, if enacted, holds the genuine promise of ameliorating nursing staff shortages in a meaningful way. Your bill, HR.901, would accomplish this by affording special pay and premiums to the most desperately needed health staff along with a relaxation of some of the bureaucratic obstacles to speedy hiring. The bill introduced by Representatives Kennedy, Ridge and others, HR.1199, addresses the nursing staff shortage by systematically enhancing nurse pay grades and by facilitating regular pay increases along with greater flexibility in offering promotions and bonuses for outstanding performance and or rewarding exceptional professional qualifications.

From our perspective both of these measures are compatible and with relatively few adjustments each should be approved by the committee. For example, HR.901 offers special pay over and above regular salaries based on longevity with the DVA. This is obviously needed to provide a meaningful retention tool to individual medical centers. On the other hand, HR.1199 would authorize medical center discretion in nursing personnel appointments "at a rate of basic pay in excess of the minimum rate of basic pay applicable to the grade in which the appointment is made...". Clearly this authority would supplement that offered in HR.901 by offering an important recruitment tool.

In both bills, it is heartening to note the inherent wisdom of giving added discretionary authority on personnel decision-making to those who most desparately need it, at the individual medical center level. As always, Mr. Chairman, the VVA appreciates your attention to its views. We look forward to working with you as well as with the Appropriations Committees on the legislation as it moves forward.

Sincerely,

Paul S Egan

Paul S. Egan
Legislative Director

NATIONAL
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OF FEDERAL
EMPLOYEES

NFFE

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STATEMENT BY

THE NATIONAL FEDERATION OF FEDERAL EMPLOYEES

SUBMITTED TO

THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

OF

THE HOUSE COMMITTEE ON VETERANS AFFAIRS

MAY 5, 1989

Mr. Chairman and Subcommittee Members:

On behalf of the National Federation of Federal Employees, which represents 14,000 employees of the Veterans Administration, most of whom work at VA hospitals and outpatient clinics, I appreciate the opportunity to submit our views on H.R. 901, introduced by Chairman Sonny Montgomery, and H.R. 1199, introduced by Representative Joseph Kennedy.

I wish to commend the sponsors of these bills for their recognition of the severe recruitment and retention problems among nurses in the Veterans Administration, and I also commend the Subcommittee for its hard work in eradicating these problems. Both H.R. 901 and H.R. 1199 have elements which, if enacted, would benefit our members. This testimony will discuss the two bills separately, and NFFE urges that a combination of what is best in both bills be created and approved.

H.R. 901

One of the most attractive elements of H.R. 901 is the two special pay proposals it includes. NFFE strongly endorses the primary special pay of $1,500 per year in addition to basic salaries for nurses. We recommend that this special pay be protected from inflation through annual adjustments based on the Consumer Price Index or the Employment Cost Index.

NFFE makes the same recommendation of inflation protection for the incentive special pay of up to $5,500 per year. The union further recommends that the list of services which merit incentive special pay of $4,000 be expanded to include psychiatric units and nursing homes. The physical stress of nursing home work, with its bedridden patients, many of whom are disoriented, has made this a very frustrating and unrewarding specialty for many nurses. Most nursing home patients will never improve, in fact, their conditions usually deteriorate. Nurses in other specialities can draw satisfaction from watching their patients become well and go home. Nursing home nurses cannot. Incentive special pay is urgently needed to compensate for the lack of other emotional rewards in the nursing home specialty.

Psychiatric nurses face not only demanding physical challenges but also encounter physical danger in their specialty. It is also important to remember that psychiatric patients frequently suffer from secondary medical problems as well, which makes the psychiatric nursing specialty a difficult one. The stress levels common in this specialty should be compensated to the same extent as emergency or operating room specialties.

The proposal to provide premium pay for Saturday duty to vocational nurses and nursing assistants is an excellent once which NFFE heartily endorses. This category should be expanded, however to include Licensed Practical Nurses and Graduate Nurses. An end to the disparate treatment between Title 5 and Title 38 employees would lessen some of the severe morale problems which have become so common in VA hospitals. At the VA Hospital in Northport, New York, for example, many nursing assistants have requested not to work weekends, since they currently receive no premium pay for doing so. The phenomenon of Title 5 personnel working next to the Title 38 personnel all weekend without receiving the same premium pay, has caused resentment and bad feelings which ultimately affect patient care.

On the subject of premium pay in general, NFFE would like to draw the Subcommittee's attention to the fact that operating room nurses in Northport, NY; East Orange, NJ; and Castle Point, NY are not receiving the extra pay for weekend duty to which they are entitled. Management at these facilities claims that there is not enough money available to make the premium payments.

H.R. 901 calls for a clarification of the limitation on outside employment for VA employees, which is prohibited because the agency wishes to be able to call on these individuals for rotating shifts. NFFE urges the Subcommittee to take another approach to this situation. If the agency would simply establish permanent day, evening and night shifts, the question of outside employment would be moot. Many private sector hospitals have permanent shifts, and NFFE cannot fathom any reason why the VA cannot do the same. Permanent shifts alone would certainly improve recruitment and retention at the VA. Nurses are leaving the agency in droves at present because their personal lives have become unacceptably disrupted as a result of constant shift rotations. It is unreasonable to expect loyalty from employees who do not receive more than one weekend off every four to six weeks.

The section of H.R. 901 that eliminates salary reductions from those VA nurses eligible for military retirement pay will be a welcome relief for many NFFE members, and has the union's support.

NFFE also supports the proposals that would allow health-care personnel to be hired without regard to the competitive civil service if they have a recognized degree or certificate from an accredited academic institution and have successfully completed a clinical education program affiliated with the Department of Veterans Affairs. NFFE support, however, is contingent on the understanding that this would not result in the individuals' becoming members of the excepted service. Excepted service employees are not entitled to the same protections as competitive service employees when faced with adverse action. NFFE is currently working to expand protections for excepted service employees, and in the interim, could not support creating a new class of excepted service members.

H.R. 1199

While NFFE is supportive of the underlying motivations for the new pay system proposed in H.R. 1199, we do not think it does as much to solve recruitment and retention problems among nurses as do the proposals in H.R. 901.

The creating of Title 38 Nurse Grades would provide the opportunity for employees in the Entry and Intermediate Grades to continue receiving step increases for as long as 40 years. Yet, by its very nature, this new system offers no incentive to move nurses into the Senior Grade unless they have earned higher academic degrees. It is not uncommon at present for nurses to be able to move into the senior grades because of longevity and experience, and NFFE fears that this opportunity will decrease if the new pay system were adopted.

The award of within grade increases or cash awards for nurses with exceptional qualifications exists already, but this portion of H.R. 1199 should be amended to standardize the procedure. Too frequently, NFFE members report that such awards are more closely tied to personalities than actual achievement. A system of clear-cut awards for specific criteria would eliminate the "buddy system" in awards and improve morale.

In addition, the list of criteria in the bill is top heavy with "paper" achievements. We question the relative importance of published articles in professional journals, as these are only secondarily related to patient care. In the same vein, if the final legislation retains service with relevant professional committees or groups and service in a responsible office in a professional nursing society as criteria for awards, then holding office in a union should also be included.

NFFE does not oppose the provision that would allow a medical center director to hire a nurse at a rate above the minimum in order to compete with the private sector. However, the union would oppose reducing pay rates for nurses who transfer to another medical center in a less competitive locality, as H.R. 1199 proposes. It is not enough to maintain an employee's grade after a transfer if the effect of the move is to reduce his or her salary. NFFE is cognizant of diverse economic circumstances across the country, and would be willing to work with the Subcommittee to create a saved-pay approach for such a situation, but an outright reduction in salary for transferring nurses would not be acceptable.

Patient Care

In any discussion of the recruitment and retention problems at the VA, it is important to note the incredible challenges VA nurses face in providing adequate patient care. NFFE members report that the appalling conditions at many VA hospitals are as much to blame for abysmal morale among the staff as are non-competitive pay rates and rotating shifts. To give the Subcommittee a feeling for the patient care conditions in the VA, we will focus on three facilities where NFFE has members: Northport, New York, Shreveport, Louisiana, and Amarillo, Texas.

Amarillo, Texas

Management at Amarillo is not filling vacancies and the hospital is currently 10% understaffed in nursing. One nurse will often be responsible for 15 patients who need IVs. Adequate staffing would require at least two nurses to care for 15 patients on IVs.

Supplies such as gloves and chux often run short, and a further budget crisis is reflected in a recent survey from management asking nurses if they would volunteer to take leave without pay.

Shreveport, Louisiana

The Shreveport hospital is short nearly 40 nurses. Frequently one RN, one LPN and one nursing assistant will be assigned to care for as many as 36 patients.

Approximately 120 beds have been closed at Shreveport because of staff shortages.

Many nurses have switched to part-time in order to look for other employment. Eight individuals did so just last month.

Staffing crises are so acute that an employee who asked for emergency leave to take her son, who had appendicitis, to a hospital was denied leave and charged with being absent without leave (AWOL). When the employee's mother died the very next day, the nurse was again denied leave and charged with a second day AWOL. The union was able to intervene, but not before other nurses threatened a wildcat strike.

Nurses are given as little as 15 minutes training on special equipment before being assigned to care for new patients on that equipment. Much of the equipment is antiquated. Many of the older, rolling IV poles will not move and there are no spare parts to repair them.

The waiting list for non-emergency surgery is months long. Supplies are short, and doctors are forced to write alternate prescriptions when the first-choice medication is unavailable.

Northport, New York

The Building Management staff at Northport has been cut from 200 employees to 112 because of budget limits. As a result, no matter how hard the employees work, they are unable to keep the wards clean and the attendant cockroach problem poses a serious health threat.

Such basic supplies as pajamas are often unavailable. Nurses in the psychiatric wards are forced to keep patients in bed or wrap them in sheets because the laundry contractor cannot supply clothing for the patients' needs. Nurses are also unable to take required universal precaution when treating patients because there are not enough gloves available. Often employees must use the same pair of gloves when treating two or more patients, and while the nurses are protected from any possible infections in this manner, the patients are at risk.

There is no escort service to take patients to X-ray and other treatments. When there is only one RN and two nursing assistants to care for 43 patients on a ward, it is dangerous for one of those employees to spend all her time transporting patients around the hospital for treatment and tests.

The pharmacy service has been closed from 4 p.m. to 8 a.m. causing a severe risk to patients. If the nurses on the ward have not accurately predicted a change in a patient's condition, medications to treat the new condition may not be available. In addition, given the short staffing on the wards, the two hours that it takes a nurse to stock a medicine cart (a task normally reserved for a pharmacy technician) represents a further reduction of hands-on patient care.

The nurses at VA hospitals are a uniquely dedicated group, who are fundamentally more concerned with proper care for their patients than they are in their own welfare. Many feel that the agency takes advantage of that dedication and then robs the nurses of the tools they need to provide adequate care.

It is clear to NFFE that disparities in how VA hospitals are run have become too great, and that Congress must intervene to prevent further deterioration in the quality of patient care. Some of the hospitals are operating more like MASH units in a war zone than a veterans hospital during peacetime. We look forward to working with the Subcommittee to improve patient care, recruitment and retention in VA hospitals.

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES
Affiliated with AFL-CIO
80 F Street, N.W., Washington, D.C. 20001

STATEMENT

BY

JOHN N. STURDIVANT
NATIONAL PRESIDENT

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES,
(AFL-CIO)

BEFORE THE

HOSPITALS AND HEALTH CARE SUBCOMMITTEE
OF THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS

U. S. HOUSE OF REPRESENTATIVES

ON

H.R. 901 and H.R. 1199

April 12, 1989

Mr. Chairman, members of the Committee, my name is John N. Sturdivant. I am President of the American Federation of Government Employees, AFL-CIO (AFGE), the largest union representing federal employees. AFGE represents approximately 700,000 federal employees in practically every department and agency in the United States. And, AFGE represents over 50% of the Department of Veterans Affairs' workers, both professional and nonprofessional, medical and medical support personnel, who are in bargaining units at DVA. For this reason, we have intimate knowledge of the cares and concerns of those employees and are in a unique position to discuss them with this Committee.

The subject of this hearing, to address some of the critical problems faced by the DVA particularly in the area of the recruitment and retention of nurses, nursing assistants and medical support personnel, could not be more timely. We commend the Committee for its recognition of the immediate need to address these problems if the DVA's mission of providing quality care to veterans is to be achieved.

Health care personnel are unique. Their humanitarian and altruistic motives for entering the health care profession in the first place, forms a solid base for continued dedication and loyalty to patient care throughout their careers. This is particularly true of the present VA employees engaged in health care. The workers who have remained with the DVA despite staff shortages and budget cuts, are clear examples of such loyalty and dedication. These employees are faced with increasing workloads as vacancies remain unfilled. These employees work overtime despite overtime pay caps. These employees cannot be spared to participate in continuing education programs to acquire new skills or to maintain and improve skills already utilized; a situation which might lead to failures to meet state licensure requirements.

Why has the situation in the VA medical centers become so acute? The answer is two-fold. There is a national shortage of nursing personnel -- not just RN's, but LPN's, LVN's and support personnel. This means that all medical facilities, both public and private, face fierce competition in attracting sufficient staff to carry out their functions. DVA is simply not in the race. Years ago, VA hospitals were often thought of as showplaces. They were in the forefront in terms of medical research and model clinical programs. The special Title 38 pay provisions insured that the VA could compete because it could offer highly competitive salaries, benefits, and opportunities for professional development. As a result, it attracted some of the best medical personnel in the country. But, alas, it, and the rest of the Federal government, has simply failed to keep pace with the changes in the private sector.

AFGE has consistently opposed alternative and special pay systems for certain groups of employees on the premise that this is disparate treatment of career employees. As it once testified before the Senate Committee on Government Affairs:

> If the Congress follows the path of trying to patch up every area of compensation as each area reaches a crisis stage, we will end up with a hodge-podge of hundreds of separate pay and personnel systems with no

> overall coherence. Such a gerrymandered pay system would be a nightmare to administer, would subvert the principle of equal pay for equal work, and likely would reduce employment mobility within the federal sector. We don't think the nation or federal employees would be served by such a result. We cannot advocate returning to the formative years of the civil service.

AFGE maintains that federal compensation should be based on the principles of comparability. In fact, it is; but the system we have has not been allowed to work and so all federal sector wages lag behind the private sector. Thus, the whole system needs to be fixed -- not just a part of it. For this reason, AFGE would normally oppose legislation such as H.R. 901 and H.R. 1199 which is an attempt to fix only a part of the problem. However, there is a major difference between VA medical personnel and personnel in other agencies. There is a national shortage of medical personnel so if DVA is not competitive, it simply will not be able to fill vacancies. In the case of other employees, there may not be a national shortage in a given field. Thus, agencies can fill vacancies in those fields but its failure to be competitive means that only those who are not hired by the competitive employers, those who may not be the best and brightest applicants, will apply for government jobs. In other words, the government is the employer of last resort.

The national shortage of nursing personnel results in:

** DVA being unable to fill vacancies

** Unfilled vacancies forces the closure of entire wards of VA medical centers

** Closing entire wards at VA medical centers means that quality care for veterans is not readily available

** Lack of quality care for veterans is indicative that DVA is failing to perform its mission.

The only way to solve these problems is for DVA to be able to attract and retain nurses and other medical support personnel from the small pool of available applicants. It must be able to offer a competitive salary and it must provide a quality work environment. For these reasons and because AFGE is totally committed to being able to provide quality care for veterans, AFGE, whole-heartedly endorses the intent of the bills -- to enable DVA to attract and retain competent medical and medical support personnel -- being considered by this Committee. However, we are concerned that neither of these bills clearly focuses on the issues nor fully addresses the problem in an equitable manner.

In order for VA medical facilities to be fully operational, they must have a full complement of personnel. Besides doctors, anesthesiologists, radiologists and other technicians, such personnel is a mix of RN's (registered nurses), LPN's (licensed practical nurses), LVN's (licensed vocational nurses), nursing assistants, clericals, orderlies, pharmacy and respiratory therapy positions. And from this mix, a few must be managers, e.g. head nurses, and the rest function in staff or line positions. The shortage in medical personnel is throughout this mix and, of course, includes nurse managers and other supervisors as well as all other medical personnel staff. Therefore, to address the recruitment and retention problems of only a part of this mix, as H.R. 901 and H.R. 1199 do, is inequitable and not totally supportable.

The pay schedule for Title 38 employees was made separate and distinct from the General Schedule for the very reason that it was believed to be necessary in order to staff VA medical facilities. Originally this worked well. However, adjustments to the Title 38 pay schedule simply haven't kept pace with the increases in comparable private sector salaries for medical personnel. Thus, DVA is already exercising its discretionary statutory authority to establish special pay rates at most VA medical facilities. It seems clear then, that what is needed is an across-the-board increase in VA salaries. The special pay provisions of H.R. 901 authorizing recruitment, primary special and incentive pay for RN's appears to be simply a short-sighted way to address part of the pay problems of just a part of the staffing mix -- RN's only. In addition, these provisions are, in reality, totally meaningless unless they are adequately funded through the appropriations process. We believe this would be unlikely in the near future. On the other hand, an across-the-board upward adjustment in the VA pay schedule would not only benefit all VA medical personnel but would almost certainly be funded as Congress appropriates monies for VA basic salaries and benefits.

Under Section 102 of H.R. 901, LPN's and nursing assistants would be entitled to the same premium and overtime pay provisions now applicable to RN's which are 10% of salary for night shift; 25% for week-ends; double time for holidays; one and one-half time for hours in excess of 40 per week; and 10% of base pay for on-call time. As pointed out above, personnel at medical facilities consists of not just RN's but of a host of other vitally important personnel as well. There is absolutely no reason why the staff support personnel directly involved in patient care should be treated any differently from RN's. This provision would eliminate this inequity. Further, the caps on overtime pay which are now applied must be eliminated and the applicable overtime principles of the Fair Labor Standards Act must prevail. To cap overtime pay is exceedingly shortsighted. The small dollar savings achieved is totally negated when the critical recruitment problem is exacerbated because personnel know that if they work overtime at the VA they will not get the normal full time and a half. Further, it makes absolutely no sense to provide compensatory time in lieu of overtime pay. The use of compensatory time simply means that fewer staff are available to provide patient care which again, only exacerbates a critical problem.

Under H.R. 901, employees paid under Title 38 would be permitted to receive outside compensation for services performed and retired military RN's would be permitted to be employed by the VA without a reduction in retirement benefits. Common sense points out what choice an applicant would make if he were considering two job offers; one from the Va and one from a nonfederal employer. If he worked for the VA his retirement income would be offset and he could not earn money in his profession from outside sources. This would not be true with the non-federal employer. Therefore, it is more than likely that the applicant would accept the nonfederal employer and once again, the VA would have an unfilled vacancy. For this reason, AFGE fully supports this Section 103 of H.R. 901 because it would enable the VA to be more competitive in seeking applicants from the small pool, nationally available.

AFGE recognizes that the present appointment process utilizing registers and centralized with OPM is often cumbersome and results in undue delays in hiring authority. The answer would appear to be to vest direct appointment authority with the Agencies. However, without strict guidelines promulgated by OPM, direct appointment authority could detract from a civil service system based on competitive merit principles. For this reason, we would suggest that Section 104 of H.R. 901 be amended to provide direct appointment authority in accordance with standards promulgated by OPM. This would achieve the desired result and would also ensure that all medical staff personnel hired throughout the federal government were subject to the same qualification standards.

AFGE was particularly pleased to see the inclusion of Section 304 in H.R. 901. This section prohibits contracting-out functions of the VA Canteen Service now performed by NAF (non-appropriated fund) employees. The opposition to this provision expressed to the Committee indicates a total lack of understanding of the provision. It does not prevent the Canteen Services from entering into contracts for goods and supplies. Rather, by its express language, it prohibits contracts "for performance by an individual not directly employed by the United States of any activity otherwise performed by an individual employed by the United States who is compensated with nonappropriated funds." So, the prohibition goes to service contracts only meaning that NAF employees cannot be replaced with contract employees over which the DVA would have no direct control. Without going into an in-depth discussion of the experience of the government with service contracts, it is sufficient to say here that experience has shown that in almost all cases, service contracts have (1) resulted in increased costs to the federal government, and (2) because there is no direct supervision, less than satisfactory performance or no performance of the services has often resulted. For example, if the contractor has unfilled vacancies or if its employees strike or engage in other forms of work slowdowns or stoppage, then the Canteen Service would suffer because the contractor would be unable to perform the services contracted for and, once again, adequate services would not be available to this nation's veterans.

H.R. 1199, introduced by Mr. Kennedy, is an entirely different approach to addressing the VA's shortage of nurses problem. The provisions of this bill, however, are only applicable to RN's thereby leaving out a large part of the mix of staff at VA medical centers all of whom are in short supply.

Rather than providing recruitment, incentive or other forms of pay believed to be necessary to recruit and retain nurses, H.R. 1199 simply divides all RN positions into four categories with the pay for each category spanning several GS grades. The pay range for each of the four categories is divided into 20 steps. RN's will be advanced a step at least every two years; head nurses will receive a two step increase, and step increases can be provided as recognition for experience, service on professional committees or in a professional nursing society, educational attainment, publication of articles in professional journals, exemplary job performance, etc. Authority is provided to appoint above the basic pay rate.

Because H.R. 1199 does nothing for LPN's, nursing assistants, and other employees crucial to the staffing mix, it fosters disparate treatment of VA medical personnel. It does have some provisions, however, which if made applicable to all medical support personnel and if funded, would have decided merit. For instance, it provides incentive pay for service on professional committees. We were pleased to note that at a recent conference of an organization which represents nurses, the staff of the Committee indicated that the intent of this provision was to recognize service in organizations which represent VA medical personnel. Those VA employees who serve as officers or otherwise actively participate in AFGE VA Locals and Councils spend a great deal of their time in striving to successfully represent the interests of the staff at the VA medical facilities, regional offices and the DVA headquarters. They would welcome and certainly deserve meaningful recognition of this untiring and almost always, volunteer service.

In summary, Mr. Chairman, H.R. 901 and H.R. 1199 are clear recognitions of the serious problem faced by the VA -- a critical shortage of RN's, LPN's, LVN's, nursing assistants and support personal due in large part because the inadequacy of pay renders the VA ineligible to compete for applicants from the small pool available due to the national shortage of such personnel. While AFGE has consistently maintained that special pay rates for certain classes of employees is not the way to fix the badly broken federal pay systems, it has just as consistently advocated that all appropriate measures available must be taken to insure that quality care is readily available for this nation's veterans.

AFGE has historically supported premium pay and overtime pay, as appropriate, for employees other than the RN's who are presently entitled to such pay. H.R. 901 provides that. However, the measures in both bills being considered go beyond the scope of providing such premium and overtime pay by providing recruitment and incentive pay but only for RN's, and in the case of H.R. 1199, of providing greater flexibility to hire beyond the parameters of the present pay ranges, but again only for RN's. So, these bills are targeted at only at a small segment of the necessary staffing mix at VA facilities, the total of which is fraught with staffing shortages.

Finally, we wish to point out that pay is not the only issue which has rendered the DVA a noncompetitive employer. Unlike their private sector counterparts, Title 38 employees at the DVA are presently denied full collective bargaining rights and in fact, due to the decision by the U.S. Court of Appeals for the District of Columbia in Colorado Nurses Association v. FLRA, July, Title 38 employees have even fewer rights than their counterparts in other federal agencies.

For many years, the Veterans Administration negotiated over working conditions pursuant to the provisions of the Civil Service Reform Act of 1978 and entered into collective bargaining agreements with unions representing both Title 5 and Title 38 employees. The one major difference in the negotiations affecting both groups of employees has been the fact that Title 38 employees have been unable to negotiate a grievance procedure to be utilized in the case of disciplinary matters. Instead, those employees have been subjected to the disciplinary boards established pursuant to Sec. 4110 of Title 38.

The Court found in the Colorado Nurses case that the Civil Service Reform Act did not override Section 4108 of Title 38 enacted some 34 years earlier. Rather, the Court determined that

Title 38 establishes an "entirely different personnel system from that embodied in title 5" which gives the "Administrator unfettered discretion to issue regulations concerning working conditions." On this premise, the Court concluded that though the Administrator may choose to bargain over matters affecting working conditions, he has absolutely no obligation to do so. Quite simply, the Court found that Title 38 "leaves no room for mandatory collective bargaining."

Congress has consistently maintained that collective bargaining is in the public interest and to the extent that collective bargaining is not inconsistent with the specific provisions of Title 38, at a minimum, the collective bargaining provisions of Chapter 71, Title 5 should be applicable to those employees at DVA covered by the provisions of Title 38.

The ability to engage in meaningful collective bargaining is a decided benefit for all employees and directly impacts on an employer's ability to recruit and retain employees. Private sector employees have such rights and only by providing such rights to its personnel will the DVA be able to compete with the private sector for qualified, capable and experienced employees.

We appreciate the opportunity to come before this Committee and present AFGE's views with respect to the staffing problems faced by VA medical facilities. We hope that our comments and suggestions will be useful to the Committee in continuing to focus attention on this problem and to find a solution which is equitable across the board. To that end, if we can be of assistance to the Committee in addressing this problem, we would welcome the opportunity to work closely with your staff.

ssa-c
4/18/89.

Statement of the

American Optometric Association

On

Recruitment and Retention of

Department of Veteran's Affairs Optometrists

Submitted to the

SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE

of the

COMMITTEE ON
VETERAN'S AFFAIRS

UNITED STATES
HOUSE OF REPRESENTATIVES

April 12, 1989

INTRODUCTION

The American Optometric Association is a professional society representing some 27,000 doctors of optometry, residents, optometry students and educators across the nation. As an organization devoted to improving the vision care and health of the public, the American Optometric Association promotes the art and science of optometry wherever it is practiced.

A Doctor of Optometry (O.D.) is a primary health care provider skilled in the diagnosis, management and treatment of conditions and diseases of the human eye and visual system, as regulated by state law.

06/4G
4/6/89

I

DEPARTMENT OF VETERANS AFFAIRS AND VETERANS NEEDS FOR OPTOMETRIC SERVICES

With the signing of Public Law 94-581 (1976), the enabling legislation which created the VA's Optometric Service, the Department of Veterans Affairs commenced recruiting qualified optometrists to begin to meet the significant demand for eye care of the veteran population. Prior to the 1976 legislation the Congress reported that two-thirds of all screened veterans required eye care, yet fewer than one in ten eligible veterans received this needed eye care because there were virtually no VA staff optometrists or teaching affiliation programs. P.L. 94-581 anticipated the recruitment of 100 optometrists (as a start), created educational opportunities for optometric interns and residents and offered more competitive salaries (via the Title 38 pay system). These improvements were judged necessary by Congress to modernize the VA's outdated practice of using only eye surgeons to provide surgical and nonsurgical care as well as primary eye care. The VA had been unique in its failure to use optometric staff, since the military and PHS as well as private HMOs and other groups generally employed two to three staff optometrists for each eye surgeon (ophthalmologist). Among the general civilian practices, there are twice as many optometrists (approximately 27,000) as ophthalmologists (approximately 13,000).

Prior to P.L. 94-581 the VA had only eight staff optometrists and one teaching program. Unlike all other federal hospital systems, the VA was forced to use eye surgeons to render not only eye surgery but also all levels of eye care, down to routine non-emergency screenings. This was noted by Congress to be a poor use of manpower and not cost-effective since there was only about one optometrist for every twenty ophthalmology staff and residents, a ratio far out of agreement with any rational distribution of medical specialties, forcing the VA to either provide primary and basic eye care so that VA surgeons would be free to perform their specialty or, inappropriately, reducing their ability to provide surgical care in an effort to provide general and primary care.

This was not cost-effective since studies indicate well over half of all veterans seeking eye care can be fully cared for by optometry staff. Further, this more rational profile would also enhance ophthalmology care and ophthalmology training programs. This could occur since, with optometry providing primary care and referral for surgery, ophthalmologists would have more time to practice this specialty and have more surgical referrals, thereby making the best use of this scarce medical resource. In other words, Congress announced to the VA in 1976 that the agency was out of date with all other federal and civilian providers of comprehensive eye care by relying solely on eye surgeons rather than a team of specialists, so that each specialty is appropriately employed. It simply did not make sense to Congress that the VA should be forced to use eye surgeons or eye surgeons in training to take time from providing their special care to also provide primary and general eye care which could be provided at less expense by optometrists. These management and cost concerns were elaborated by the GAO when it studied the VA's implementation of P.L. 94-581 (Study, The Role and Use of Optometry in the VA Needs Improvement, GAO, June 21, 1978). The GAO also cited the inappropriate use of eye care manpower by the VA as well as the general failure to implement at least 200 full-time optometrists and the creation of significant numbers of optometry teaching affiliations. The GAO also noted that in all other systems rendering eye care there were more optometrists than eye surgeons, yet the VA continued to be unique in having a reverse staffing ratio.

In its reply to the GAO study, the VA acknowledged the optometry staffing shortage and stated it was hiring, as a first step, 30 full-time optometrists and would, over a multi-year period, hire additional staff called for by Congress. The VA also stated this was a first step and agreed with GAO that about 200 full-time optometrists were needed in all. The VA also agreed it had not created significant numbers of teaching affiliations and these would also be implemented.

Again in 1982, Congress asked the VA where it stood in modernizing its eye care by securing appropriate numbers of staff optometrists. First initiated by a letter from Senator Thurmond for detailed information on the development of the optometry program, this request was broadened in scope by Congressman Montgomery to include not only all eye clinics but both optometry and ophthalmology manpower, their working relations, the impact upon eye care (quality and quantity) by optometrists, and the opinions of the hospital chiefs of staff on the effects produced by the use of optometry staff. This inquiry by Senator Thurmond and then by Congressman Montgomery was first triggered by a concern that the VA had still, some seven years since passage of P.L. 94-581, only added about 55 of the 100 optometrists intended by Congress via P.L. 94-581.

The VA developed a survey questionnaire and conducted a survey in order to answer the congressional inquiries. This 1983 survey, conducted and jointly prepared by the VA's Surgical Service and Optometric Service, was endorsed by the VA's Department of Medicine and Surgery and transmitted to Congress in April 1983 as the agency's response to the issues raised by the congressional inquiries.

The survey reported data from 168 of the 172 VA medical centers and remains today, six years after its release, the most comprehensive and exhaustive study to date. The study reported deficiencies and positive aspects of VA eye care. Some of these are encapsulated below:

Deficiencies Cited by the Study

- "The bulk of clinical staff is provided by ophthalmologists and residents in ophthalmology. Total ophthalmology staff is 372.2 FTEE (includes 235 residents) as compared to a total optometry staff of 92.3 FTEE (includes 26 residents). There are 0.25 optometry FTEE for every 1.0

ophthalmology FTEE. This ratio is low and is compared with other general health care systems (HMO, DoD, civilian) in Figure 3 where the range is from 2.5 to .9 optometry FTEE per ophthalmology FTEE." (Survey, Introduction, pg. 2).

- Average waiting time for eye appointments was 38 days, with 84 centers in excess of 30 days and 73 centers having restricted acceptance of eye clinic appointments. (The ACMD for Professional Affairs determined any delay over 30 days to be unacceptable). In fact, 41 medical centers had delays in excess of 60 days.

- Twenty-eight stations had no eye clinic staff and 93 stations reported less than 0.1 FTEE optometry staff (less than 4 hours' staff coverage per week).

- There were 85 medical centers with ophthalmology teaching programs and only 41 with optometry teaching affiliations, with 235 ophthalmology residents being trained while only 26 optometry residents were in training.

Positive Study Findings

Seventy-three medical centers reported having both optometry and ophthalmology staff and at these 73 stations which had initiated team eye delivery as envisioned by Congress via PL 94-581, their chiefs of staff reported:

- At 56 centers, the chiefs of staff reported the professional cooperation between optometry and ophthalmology to be "excellent"; 15 reported "good" relationships; 2 reported "acceptable" and not one responded in the two remaining categories of "fair" or poor".

- "All 73 (chiefs of staff) reported their optometry sections had increased the type, scope and quality of their station's eye/vision care". (Survey, Summary of Findings, pg. 1).

- All 73 chiefs of staff reported that timely and appropriate referrals were being made by optometrists to ophthalmologists.

The VA report made a detailed station by station analysis of patient workload and staffing profile, waiting time for eye appointments and requests for resources. After careful review the report states:

> "Based upon a review of each VAMC's response, its eye/vision needs, staff levels, affiliations, waiting times, and Rx activities, it was determined that 66 VAMC's needed increased optometry staff coverage and 26 needed increased ophthalmology staff coverage. These equate to 46 FTEE additional optometry staff and 9 FTEE additional ophthalmology staff."

Thus, the 1983 Survey again confirmed that while the VA made some effort to implement a more rational cost-effective eye care delivery system it had fallen far short in correcting the deficiency. For example, the total full-time optometry staff in 1983 was 67 (73 in 1989) far short of the 10% that would have resulted from adding the 100 called for by Congress in 1976.

Additional Evidence Demonstrating Cost-Effectiveness of the VA Optometry Staff

In addition to the above well-documented need for and desirability of optometry staff, futher evidence has recently been revealed following an investigation of the VA's Resource Allocation Methodology (RAM) information.

The key feature of VA eye care delivery criticized by all past studies has been the VA's inability to better tailor its eye care staffing to its patient care needs by primarily having only eye surgeons and their residents available. Thus, the VA was providing entry level, primary care as well as secondary and tertiary care using these tertiary care providers. As previously noted, such a staffing profile is not used by other similar federal providers. This use of tertiary care providers resulted in a comparatively high cost-per-treatment episode since expensive and scarce eye surgeons had to be "all things to all people" under the antiquated VA system.

Even though the VA has fallen short of adding appropriate numbers of optometrists, there now exists a statistically significant number of jointly staffed team eye clinics with optometry and ophthalmology staff, residents and students.

The RAM's system tracked the cost-to-benefit ratios of different patient care services within each hospital. The RAM-generated data supports the opinion of Congress that greater use of optometry staff is cost-effective; the marginal cost-per-treatment episode has decreased dramatically with the introduction of optometry staff. That is, adding optometry staff to produce a more rational staffing profile greatly expands the number of patients who can be treated, reduces patient backlog and significantly lowers the cost-per-treatment episode. The VA has documented what many other eye care provider models have maintained for years: optimum and least-costly eye care results when using a staff of optometrists and ophthalmologists in proportion to the need for their services.

To conclude this portion, all evidence to date indicates Congress was correct in creating an Optometric Service and calling for optometry staff and training programs as a means to improve VA patient care and to lower cost-per-treatment episodes. This is more important today than in 1976 due to the constantly shrinking federal dollar. Yet the VA is unable or unwilling, even in the face of a preponderance of evidence from both outside and within the Department, to approach minimal staffing levels that it has publicaly acknowledged should be met. In view of the severe budgeting problems facing the VA where each federal dollar must provide the maximum in cost-effective patient care coupled with a rapidly aging veteran population and its attendant increased eye care problems, the VA should act now to make the best use of its resources. With the ever-increasing numbers of eye care problems needing treatment in this expanding veteran population, the VA can ill afford to defer meeting its self-acknowledged staffing needs. To do so would be both fiscally and medically inappropriate.

II.

THE EXISTING OPTOMETRY PROGRAM AT RISK

Section I, above, dealt with the VA's failure to adequately recruit optometrists and develop the optometry program. This section addresses matters which are weakening the present optometry program so that, even in the face of proven excellent results, the VA is in danger of failing to preserve it. At the heart of this are the issues of recruitment and retention.

Non-Competitive VA Optometry Salaries

In 1976, PL 94-581 cited poor salaries as a central factor inhibiting the hiring of staff optometrists. By moving VA optometrists to the Title 38 pay structure, salaries were created which began to approach those in the private sector. While falling short of 1976 private practice incomes, these VA salaries were sufficiently competitive that high quality optometrists interested in hospital-based practice, as well as teaching affiliations, were successfully recruited. These individuals are now the senior clinic chiefs within the VA system and have developed both patient care, teaching and research programs, as a testament to the quality of staff initially recruited. Unfortunately the VA optometrists' salaries have not kept up with the increases in the private sector, particularly at mid and advanced career levels. The result is that increasing numbers of senior VA optometrists are leaving the system. These experienced VA clinicians are accepting leadership positions in other health care centers and teaching institutions. The salary gap is significant. Available data show the average full-time optometrist's salary to be about $46,300., while the privately practicing optometrist has a net income of about $62,700. This means the average VA salary is 35% below the average for the private sector. This salary gap is more critical because the VA optometrists are widely recognized to be of particularly high caliber in professional ability while having increased patient care responsibilities, due to training and the demands of the medical center environment.

The salary gap problem cascades down to the VA residency program as well since all of these training programs are directed by these key senior optometry staff. With the absence of training program directors, the optometry residency program suffers.

In addition to the increasing retention problem, the VA if it chose to recruit optometrists to complete the long-deferred development of the optometry program, would face a serious recruitment problem. Since the VA has failed to recruit the optometrists it says it needs, few positions are available and consequently recruitment is not even attempted.

The effect of the salary gap is further compounded by the development of additional opportunities for practice in a medical environment, similar to the VA so that the VA has lost some of its recruiting potential. The attributes of a team approach to eye care, emphasizing cost effectiveness as espoused by Congress in 1976, can be seen in the private sector. In the past five years, there has been a rapid development of "co-management centers" whose key feature is team delivery care by optometrists and ophthalmologists. These centers now offer a medical environment attractive to recent optometry graduates. In the past few years, many VA residents have been recruited to them following their VA training. In fact, many of these centers and schools of optometry require residency training (of which the VA provides the bulk) for appointment to the co-management center group. These attractive modes of practice, coupled with the expanding salary gap, have left the VA unable, in the main, to recruit its own residents even though a prime reason for such residency programs is to recruit VA staff. Also, the co-management centers have recruited half of their clinic directors from the ranks of the senior VA optometrists. The problem can be distilled to the fact that the VA, having established a standard of excellence for its staff training program, has allowed salaries to fall behind to such a degree that both its residents and senior staff are now rapidly being recruited away; the consequence is that the investment the VA made in those programs is beginning to evaporate. It seems clear that another adjustment in salaries must be accomplished because the slippage since 1976 has produced salaries which are now about 35% below the average for private incomes. This salary adjustment is even more critical since the VA optometrists have exceptional demands made of them in their work environment. While we understand and appreciate the VA cannot be expected to fully match salaries offered by models and opportunities outside the VA, it should be expected that the VA could provide some monetary inducement as a signal that VA optometrists represent a highly valued resource. Such an indicator, when coupled with the admittedly professionally stimulating environment would allow the VA to retain these exceptional practitioners. But the VA cannot hope to retain these individuals with average salaries 35% below private practice. And the VA cannot hope to retain faculty caliber senior staff with salaries 35% below average incomes. Finally, while the VA has admitted its optometry program is small (smaller than is required or anticipated by Congress), it has correctly prided itself on the quality of service. That quality is now showing the cracks of erosion and without some salary augmentation, the program is destined to erode to an unacceptable level. This erosion will spread and not only damage patient care but teaching affiliations as well since the two are interrelated.

To conclude, the VA Optometric Service and its teaching affiliations are currently of high quality. All available evidence proves the wisdom of Congress when, in 1976, it instructed the VA to modernize its eye care by building an Optometric Service. Increased numbers of patients are now being given higher quality and more comprehensive eye care at a lower cost-per-patient treated. Better use is being made of scarce eye surgeons, and reports from chiefs of staff unanimously agree that team delivery by optometrists and ophthalmologists is a quantum improvement; the VA has evidence of increased productivity as well.

Unfortunately, in the face of over a decade of consistent positive data, Congressional urging and even its own studies, the VA has not honored its pledge to build its optometry program to even the lowest level recommended. Since 1983 when the VA's own study cited an immediate need for 46 optometrists, it added just 6. This performance, viewed against a background of the ever-increasing requirement to be more cost-effective and reduce cost-per-patient treated, is simply inadequate.

Finally, the VA is not acting to preserve the small but excellent program it has created. The salary gap can no longer be ignored. The VA must begin to ameliorate the situation before the quality is damaged and the cost-per-patient is increased. We urge prompt attention to the salary gap disparity for the VA's doctors of optometry.

We thank the Committee for the opportunity to offer our views and present the case for the VA's optometry program. We hope this statement will assist the Committee in its deliberations on recruitment and retention problems of VA doctors of optometry.

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MILITARY ORDER OF THE PURPLE HEART
CHARTERED BY CONGRESS

STATEMENT OF
THE MILITARY ORDER OF THE PURPLE HEART

BY

ROBERT L. ALVAREZ

NATIONAL SERVICE DIRECTOR

AND

EDMUND E. JANISZEWSKI

NATIONAL LEGISLATIVE DIRECTOR

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

VETERANS AFFAIRS COMMITTEE

U.S. HOUSE OF REPRESENTATIVES

ON

VARIOUS VETERANS HEALTH CARE INITIATIVES

APRIL 12, 1989

5413-B Backlick Road, Springfield, Virginia 22151 (703)642-5360
EXCLUSIVELY FOR COMBAT – WOUNDED VETERANS

Mr. Chairman and Members of the Subcommittee, The Military Order of the Purple Heart appreciates this opportunity to present our views on H.R. 901 and H.R. 1199.

H.R. 901 "To improve programs for the retention of health-care personnel of the Department of Veterans Affairs and for other purposes."

Section 101. The Military Order of the Purple Heart is in favor of this iniative to improve recruitment and retention of qualified nurses. However, we also believe that first the Department of Veterans Affairs must properly fund the current FTEE properly and not divert funds from the FTEE to other programs. The full blame for the current nursing shortages cannot fully be blamed on a shortage of nurses, due to low salaries. It is a due to a combination of money shifted from the FTEE, over-work of nursing staff due to FTEE shortages and to salaries.

Consequently, we believe without addressing both problems at the same time, nothing will have been accomplished. This also points to a further problem, if DM&S is utilizing money earmarked for FTEE and other areas, are they understaffing their eintire budgetary needs. If so, they are the prime cause of this crisis. If the money to be authorized under this progressive proposal going to be further misused for other shortages rather than the intended purpose.

Sec 102. The MOPH fully supports this proposal, provided as stated above, money earmarked for this program is used only for its intended purpose.

Sec 103. The MOPH has no objection to any provision in this section and comment the committee for its foresight.

Title II Sec 201. MOPH supports your ammendment to make the respite care program permanent.

We also support the extension of the state home grant program to 1992. The State Veterans home program furnishes domicilliary and nursing home care and delivers the strain on the VA medical system for additional chronic care units at a fraction of the cost.

Title III Sec 301. MOPH supports basic premise of this program and believes that vigorous collection of fees and other amounts due the Veterans Administration is a must and would provide supplemental funding for the DVA medical programs. This should be carried out by all medical regions simultaneously with the implementation of an automated collection system. Realistic standard fees should be charged comparable to the private sector. We further believe that the collected monies should be apportioned to the hospital or district to fund the cost of collection, to reward their efforts and improve their services. A percentage to fund recruitment and retention and a percentage for the medical director's use for other programs. We can find no conflict with this section as long as collections are confined to third party reimbursement from health insurance sources, collections from veterans and the waiver by the DVA of any veterans share should be mandatory.

Sec 302. The MOPH cannot support any sharing agreements with DOD until the DVA can restore treatment to all categories of veterans and restore the Department of Medicine's full FTEE at each hospital.

Recently, one of our members was taken from a DVA nursing facility to a DVA hospital for treatment. He was left in the out patient treatment area the entire day in a wheelchair, with no food, no water and his biological needs were not attended to. This was inhumane and criminal. This is only one of many cases we and other service organizations can cite.

Sec 303. ChampVA Program. The Order cannot object to the improvement in eligibility determinations and reporting.

Sec 304. The MOPH supports this ammendment in toto.

H.R. 1199 "Veterans Nurse Pay Act of 1989"

In general, the MOPH supports this bill as it is a strong complement to H.R. 901. We are especially pleased with section 3 annual report in delays in ordering prosthetic services. The delays in prosthetic services has been hard felt by our membership as our members are all combat wounded. We would like to see priority given to the combat wounded over other eligibles for this service.

The Military Order of the Purple Heart wishes to thank the Chairman, Congressman Kennedy and all cosigners of these two bills for their foresight and support to our nation's veterans and their needs.

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

JUN 14 1989

Honorable G. V. (Sonny) Montgomery
Chairman, Committee on
Veterans' Affairs
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Enclosed please find the Department's responses to questions raised by you and Representative John Paul Hammerschmidt following the April 12, 1989, hearing on H.R. 901 and H.R. 1199 and other Health Care Legislation. A copy of these responses has been provided to Representative Hammerschmidt.

Sincerely yours,

Edward J. Derwinski
Secretary

Enclosure

cc: Honorable John Paul Hammerschmidt

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSE

CONGRESSMAN MONTGOMERY

Question: 1. What incentives exist for the VA to assume claims processing for the CHAMPVA program "in-house" compared to hiring non-federal experts to perform the function? Does the VA have any in-house experience for these complicated processing activities?

Answer: There are numerous incentives for the VA to assume claims processing for the CHAMPVA program "in-house." Foremost is the opportunity to centralize administration of the CHAMPVA program thereby enhancing the system's efficiency and integrity. Reliance on external contractors to perform the claims processing function fragments procedures, requires a greater length of time to process claims, and results in additional administrative costs to VA. VA has already revamped CHAMPVA eligibility determination procedures and set up a Central CHAMPVA Registration Center (CCRC) where all CHAMPVA beneficiary files are maintained. Use of the CCRC and other existing resources would make it easier for VA to verify claims by cross referencing claim forms with sponsor and beneficiary files. Centralized access to this information would serve to reduce the incidence of erroneous payments and facilitate follow-up in third party liability cases. Exercising complete managerial control over the CHAMPVA program would thus enable VA to streamline procedures, increase accuracy, reduce turnaround time, and improve beneficiary satisfaction.

Question: 2. According to a January 19, 1989 white paper, the VA was advertising for "key supervisory staff position for the CHAMPVA processing program." How many positions remain unfilled as of today? What percent of the total remain unfilled today?

Answer: There are 10 key supervisory staff positions for the CHAMPVA Center. As of this date, 5 of these have been filled.

50% of key supervisory staff remain unfilled as of this date.

Question: 3. According to a January 19, 1989 white paper, the VA was "working on an automated payment system for the (CHAMPVA processing) center. Will it be ready by September, including the utilization management and medical care cost recovery system? How is the VA using the experience gained in the private sector in utilization management?

Answer: As of today, that is still the target date.

The development of our QA-UR program is being done by using solicited material from private sector sources such as Blue Cross and Blue Shield, Kaiser, and DELMARVA. In addition, OCHAMPUS fiscal intermediaries, who are private sector, have provided source material for incorporation.

Question: 4. Medical Region 3 has had some experience with the use of a private firm to handle your billing and collections for third party payments for care of non-service-connected veterans. What is your estimate of possible collections from such a program? What is the current level of collections in your region?

Answer: There are no facilities in Region 3 that currently have private firms handle their billing and collections for third party payments for care of non-service-connected veterans. Current collections in Region 3 for October 1988 through March 1989 are $2,077,854.

Question: 5. GAO estimated in 1985 that it costs the VA $26 to process a single third-party bill while the private sector can process these same bills for between $2 and $5. Even if the estimated private sector cost is higher than that, why would the VA want to establish it's own in-house capacity especially with the limited resources that the VA has to run its operations?

Answer: At the time of the GAO review, all bills were being prepared manually by the VA. In addition, private sector costs are lower due to less manpower being required. The VA is required to gather the data, prepare the bill and handle collections. The private agencies only have to prepare the bill and handle collections. All information must be gathered by the appropriate facility and provided to the private concern for their preparation of the bill.

CONGRESSMAN MONTGOMERY

Question: 6. When will the Decentralized Hospital Computer Program (DHCP) be able to support a billing and collection system for third party payments? What will the VA do in the meantime to support an in-house system? Why could the VA not use the private sector in the interim period?

Answer: The initial DHCP medical care cost recovery system was forwarded to the field stations for use beginning November 1, 1988. This package allows the facilities to generate bills for third party insurance companies, means test co-payments and all other instances where the care was rendered at VA facilities. The most recent version of DHCP for Fiscal Service includes the capability for the amounts billed to be automatically entered into the Accounts Receivable program at the facility when the bill is actually generated. Complete automation of this activity should be accomplished by the beginning of FY 1990. In the interim, we are aggressively pursuing recovery through our already established in-house methods.

Question: 7. Part of the suggested changes in the Compensated Work Therapy program include the authority for the VA to buy and sell housing in the community for use of VA patients in the program. Would the authority to lease such housing accomplish the goals that you see for the program?

Answer: VA is still studying the best means by which the compensated work therapy program and other authorities can assist veterans, and is unable to offer specific recommendations at this time.

Question: 8. By law when a veteran is placed in a community nursing home, the maximum length of stay at VA expense is six months unless an extension is granted. The VA has had a policy since April 21, 1988 to limit the extensions on community contract nursing home stays to forty-five days. What kind of "savings" has this resulted in?

Answer: VA has not experienced any substantial savings as a result of this policy change. The number of contract extensions beyond six months was so small, less than 2 percent of more than 40,000 patients treated, that savings were not anticipated.

Question: 9. Last year, the VA testified that information would be collected on the frequency of extensions beyond the 6-month limit for nursing home care in community facilities for non-service-connected veterans. What can be reported in that regard today?

Answer: In Fiscal Year 1988, 776 nonservice-connected veterans were granted 45-day extensions beyond the 6-month limitation in the Community Nursing Home Program.

Question: 10. How much would the leave sharing program requested by the DVA cost the VA?

Answer: There are no new costs associated with the leave sharing program. We estimate the leave sharing program for Title 38 employees would cost the VA less than $50,000 the first year with decreasing costs in subsequent years for administrative expenses. This figure represents the payroll cost for hours worked by current employees to administer the program.

Question: 11. H.R. 901 requires the secretary to compile a list of eligible beneficiaries under the CHAMPVA program. I understand that you have already started this. What amount of savings do you project will be provided by having such a list? What further steps do you plan to take to obtain further savings? For example, have you considered a utilization review system?

Answer: The IG audit findings state "In fiscal year 1987 the VA will lose about $14.5 million in direct care and administrative costs for services to ineligibles." We accept these findings as projections of savings associated with the purge of ineligibles from our beneficiary list. $20 million has already been identified for reprogramming.

CONGRESSMAN MONTGOMERY

The CHAMPVA Center will have a designated unit devoted entirely to CHAMPVA third party liability recovery actions. According to the IG audit findings, "we estimate that in Fiscal year 1988 the value of TPL's that should be pursued will be about $4.5 million." With the focus on this activity, our expectations correspond with these findings, which further reinforces the benefits of centralizing this process.

A utilization review system is planned for incorporation in the CHAMPVA Center, to be implemented simultaneous with on-line CHAMPVA claims processing.

Question: 12. What recommendation did the Director of the Canteen Service, Robert Mantica, make with regard to the proposal in H.R. 901 about making the Canteen Service independent of the Chief Medical Director.

Answer: While recognizing there are advantages and disadvantages to this proposal, Mr. Mantica has not made a specific recommendation in this regard.

Question: 13. Improved pay is always listed as an important incentive health care professionals to come to work at the VA. What other ideas are being considered by the new office of health care staff development and retention?

Answer: The following actions have been taken to improve our recruitment and retention stance:

- The third annual Survey of Health Occupational Staff is underway. The data, which should be available May 1989, will be used to assist in the evaluation of recruitment and retention trends throughout the Department. This data will assist in the development of the expanded data base to assist in the analysis of staffing and potential shortages.

- We are in the process of implementing an image enhancement program to improve our perception as a preferred health care employer. This campaign will initially focus on efforts to improve the recruitment and retention of nurses, pharmacists, occupational and physical therapists, and other scarce occupations.

- A VA Task Force recently convened February 1989 to examine the current Title 38 pay system for nurses and to develop strategies for improvements in both the administrative and legislative arenas.

- In March 1987, the Chief Medical Director charged a Task Force to study problems of recruitment and retention of nonphysician health care workers to make recommendations for their long term solution. The Task Force agreed that, in most geographic areas, the VAMCs do not provide keen competition for quality health care personnel when compared to the private and even university affiliated hospitals. We frequently fall short in several of the following categories: base salaries, benefit packages, workload or staff/patient ratio, effective recruitment and publicity efforts, and amenities of the workplace. An Action Plan has been developed and approved to implement the recommendations of the Task Force.

- The Office of Health Care Staff Development and Retention is responsible for the execution of the Action Plan developed to implement the approved recommendations of the Task Force. In addition, this office will give national focus to recruitment and retention efforts and concerns and serve as an information clearinghouse.

CONGRESSMAN MONTGOMERY

- Also, we are in the process of addressing the following established under Public Law 100-322, "Veterans' Benefits and Services Act of 1988":
  - Mandatory Saturday premium pay for registered nurses;
  - Tuition reimbursement for those employees pursuing nursing degrees;
  - Study of various alternative pay, personnel management, and benefit practices in the interest of improving our competitive recruitment and retention stance;
  - Child care center operation at VA facilities;
  - Health Care Professional Scholarship Program expansion;
  - Conversion of pharmacists and occupational therapists under "hybrid Title 38".
- A variety of regional and local initiatives are being monitored throughout the system. These efforts will be formalized into a clearinghouse function that will serve to ensure the broadest dissemination.
- Funding is being sought for the FY 90 budget for the VA Learning Opportunities Residency Program. This program was developed as a recruitment tool to measurably increase the number of BSN prepared nurses in specific hard to recruit clinical areas.

Question: 14. Last year, the VA testified that it hired only about 6 percent of 50,000 students in allied health professions who trained in VA clinical education programs. Has that employment rate improved any? Do you believe that a direct hire authority for these students would help?

Answer: There has been no change in the employment rate for affiliated students. Direct hire authority would help improve this employment rate.

Current law prevents the hiring of many allied health students upon graduation without first undergoing the complicated and often lengthy process required under the civil service competitive system. Thus, when a highly-qualified student in a title 5 "allied health-care" profession with excellent training in an affiliated clinical education program at a VA facility receives his or her professional degree and expresses an interest in working at the VA facility, the facility is unable to offer that professional a position until the entire civil service process is completed. The result is that highly motivated potential employees become frustrated with the length and complexity of the procedures and accept offers elsewhere. The direct hire legislation would enable VA to meet current and future shortages by offering employment as rapidly as other health-care employers with whom we compete, and take advantage of training relationships by allowing the Department to secure career commitments even in advance of graduation.

VA is experiencing staffing shortages in many of these "allied health-care" areas, and the situation could get worse. There is a decreasing number of individuals entering these training areas and intense hiring competition for these professionals, especially recent graduates.

Question: 15. The reporting requirement for the Special Committee on PTSD expires next year. Would the Department be in favor of extending the reporting requirements under its current guidelines? If not, why would the Department not favor this?

Answer: The Chief Medical Director's Special Committee on PTSD was established by Section 110(b) of Public Law 98-528. As required by the law, members of the Special Committee are to be qualified VA employees. Responsibilities of the Special Committee include carrying out a continuing assessment of the VA's capacity to provide diagnostic and treatment services for veterans with PTSD and advising the Chief Medical Director on the development of policy and guidance and the coordination of services for the diagnosis and treatment of PTSD. The Special Committee is also responsible for providing recommendations to the Chief Medical Director concerning: appropriate diagnostic and treatment methods, referral for and coordination of follow-up care, the evaluation of PTSD treatment programs, PTSD research activities, PTSD educational activities and the appropriate allocation of resources for all such activities.

The law also required the Administrator to submit five annual reports to Congress on the implementation of provisions contained in Section 110 of Public Law 98-528. Among other things the reports were required to contain the recommendations made by the Special Committee and the views of the Chief Medical Director on such recommendations. The VA's 1989 report is the fifth and final report to Congress required by this legislation.

During the last five years, the Special Committee has chosen to provide the Chief Medical Director with information and recommendations through its own annual reports. In turn, the VA has forwarded to Congress all the Special Committee's reports to the Chief Medical Director so that the Congressional Committees would have the detailed information contained in the Special Committee's reports as well as the rationale behind its recommendations to the Chief Medical Director. The Special Committee's reports have always been accompanied by the Department of Veterans Affairs reports which contained the Chief Medical Director's views on the Special Committee's recommendations.

Public Law 98-528 does not call for discontinuing the CMD's Special Committee on PTSD. In fact, VA intends to continue to have the Special Committee serve as an advisory committee to the Chief Medical Director. Thus, we see no need for legislation on this subject. Similarly, we do not believe that requiring VA to prepare a detailed point-by-point response to Congress annually on its own committee's recommendations is a useful exercise. It deprives VA of sufficient opportunity to factor the committee's recommendations into the budget process, for example. Thus, it is not clear that such reporting helps either VA or the Congress.

Question: 16. In previous testimony, the Department has stated that the DVA is short about 2,400 nurses. In testimony today, the DVA estimated the cost of conversion to H.R. 1199 to be about $36 million. Does this figure include the hiring of these additional nurses? If not, how much more would it cost the DVA to implement H.R. 1199 if these additional 2,400 positions were filled?

Answer: The estimated cost of conversion provided at the HVAC hearing did not include the vacant nurse positions. If these positions were filled, it is estimated that conversion to H.R. 1199 would cost an additional $2,366,400.

CONGRESSMAN HAMMERSCHMIDT

Question: 1. What is the average entry level salary for a new graduate nurse at the VA? Is this number competitive with private-sector starting salaries?

Answer: New graduate nurses enter at either the Junior or Associate grade level. The average starting salary for a full-time Junior grade nurse was $22,641 as of December 31, 1988. The average starting salary for a full-time Associate grade nurse was $24,340 as of December 31, 1988.

The Management Science Associates (MSA) Report, dated April 1988, reported average nationwide starting rates for new hires to be $21,154. The study also stated that the average maximum a new hire might receive was $24,939.

Question: 2. Your testimony states that there are currently 125 special pay agreements are in effect at the VA for nurses. What is the estimated cost to the VA of these special salary rates?

Answer: The estimated cost of the VA special salary rates for nurses is $65.6 million.

Question: 3. H.R. 901 would provide primary special pay of $1,500 added to the base salary of VA nurses. If H.R. 901 were implemented, how many of the 125 VA hospitals currently utilizing special salary rates would no longer need them.

Answer: Since special pay for nurses is discretionary, i.e., the nurse has the option of signing a special pay agreement or remaining on special salary rates, it is difficult to estimate the total impact the $1,500 increase would have on special salary rates. Unless all the nurses at a facility covered by special salary rates enter into special pay agreements, it is conceivable that the special salary rates would still be needed. In some locations where the special salary rates are very high, the amount of special pay the nurse would receive under HR 901 would not be large enough to completely offset the special salary rates currently authorized for the facility.

Question: 4. The majority of hospitals in the VA system must use special salary rates to retain registered nurses. This is the rule rather than the exception, as the law originally intended it to be. Would not it be easier from an administrative point of view to simply elevate the base salaries?

Answer: Yes. We are currently in the process of examining our current pay system and developing strategies for an alternative pay system.

Question: 5. If we elevated the base salary as proposed in H.R. 901 and implemented the incentive pay provisions, could you come up with an estimate of what percent the individual hospital's budget would have to be increased?

Answer: It is estimated that on an average, individual hospital budgets would need to be increased by two tenths of a percent for 1990 and six tenths of a percent for 1991. This is based on our cost estimate of the bill compared to the 1990 appropriations request.

Question: 6. According to the Bureau of Labor Statistics, workers under the General Schedule lag 22 percent behind comparable nongovernment workers. Is this statement true with regard to VA nurses?

Answer: As of 12/88, the average VA staff nurse salary, including special salary rates, was $30,297 per year. The average VA nurse grade and step was 10/4, which, under the 1988 statutory pay schedule, equates to an annual salary of $27,749. The average nationwide staff nurse salary, based on the 7/1/88 Cole Survey, (published in the 12/88 edition of Modern Healthcare), was $26,200.

CONGRESSMAN HAMMERSCHMIDT

Question: 7. The attrition rate of R.N.s leaving the VA is approximated at 26.5 percent per year. The cost of replacing that individual can be quite high because it includes such factors as advertisement, active recruitment, interviewing, checking references, orientation, and inservice education and training. Taking into consideration these factors and any other relevant costs, can you estimate the average cost to the VA each time a nurse leaves the VA?

Answer: The VA does not have an accounting system to track the cost to replace nurses. In 1981, one researcher estimated the cost to be $2,500 to $3,000 to replace a nurse. The HHS Secretary's Commission on Nursing's Interim Report, dated July 1988, cites an estimated cost of $20,000. VA operates a continuous health care recruitment program which includes major conventions and job fairs on the national, regional, and local level as well as developing advertisements for major professional journals, career guides, newspapers, and flyers. The personnel staffs at our medical centers who are responsible for staffing health care occupations generally are responsible for providing a range of personnel management activities, not just recruitment. Thus our costs associated with these efforts are relatively fixed and not so focused on a vacancy-by-vacancy basis as found in the private sector. For example, we typically do not use employment services which charge hefty fees for each person that they recruit and place. Further, the broad scope and continuous nature of our program makes it almost impossible to arrive at meaningful estimates of the average cost to the VA each time we lose a nurse. As an aside, it should be pointed out that the 26.5% turnover rate from our Survey of Health Occupational staff include transfers to other VA facilities.

Question: 8. The National Commission on Public Service (also known as the Volcker Commission) studied the civil service for nearly 2 years and recommended a decentralization of Office of Personnel Management's current operating responsibilities. Would proposals for decentralization such as those contained in Sections 103 and 104 of H.R. 901 achieve this goal?

Answer: Yes. By themselves, they represent a small fraction of the broad-scope delegation recommended by the Volcker Commission, but they appear to be of the type of delegation the Commission had in mind.

Question: 9. Do shortages of allied health professionals contribute to the shortage of R.N.s?

How is the VA addressing the shortages of allied health professionals which exists in the VA?

Answer: The need to perform duties normally performed by other health care professionals often causes an increase in workload. The VA's 1988 Survey of Health Occupational Staff Preliminary Report states that 8.4% of R.N.s left VA employment due to workload.

The following actions have been taken to improve our recruitment and retention stance:

- The third annual Survey of Health Occupational Staff is underway. The data will be used to assist in the evaluation of recruitment and retention trends throughout the Department. This data will assist in the development of the expanded data base to assist in the analysis of staffing and potential shortages.

CONGRESSMAN HAMMERSCHMIDT

- We are in the process of implementing an image enhancement program to improve our perception as a preferred health care employer. This campaign will initially focus on efforts to improve the recruitment and retention of nurses, pharmacists, occupational and physical therapists, and other scarce occupations.

- In March 1987, the Chief Medical Director charged a Task Force to study problems of recruitment and retention of nonphysician health care workers to make recommendations for their long term solution. The Task Force agreed that, in most geographic areas, the VAMCs do not provide keen competition for quality health care personnel when compared to the private and even university affiliated hospitals. We frequently fall short in several of the following categories: base salaries, benefit packages, workload or staff/patient ratio, effective recruitment and publicity efforts, and amenities of the workplace. An Action Plan has been developed and approved to implement the recommendations of the Task Force.

- The Office of Health Care Staff Development and Retention was recently established and is responsible for the execution of the Action Plan developed to implement the approved recommendations of the Task Force. In addition, this office will give national focus to recruitment and retention efforts and concerns and serve as an information clearinghouse.

- Also, we are in the process of pursuing the following established under Public Law 100-322, "Veterans' Benefits and Services Act of 1988":

    - Study of various alternative pay, personnel management, and benefit practices in the interest of improving our competitive recruitment and retention stance;
    - Child care center operation at VA facilities;
    - Health Care Professional Scholarship Program expansion;
    - Conversion of pharmacists and occupational therapists under "hybrid Title 38".

- A variety of regional and local initiatives are being monitored throughout the system. These efforts will be formalized into a clearinghouse function that will serve to ensure the broadest dissemination.

Question: 10. What is the average percentage of outside, contract nurses who are brought in to fill vacancies in the VA due to shortages of R.N.s?

Typically, contract services are quite costly. Can you estimate approximately how much the VA is spending annually on contract nurse services?

Answer: It is estimated that on 12/31/88, the VA had 35,915 (full-time, part-time, and intermittent) nurses on board. Also, during FY 88 it is estimated that the VA contracted 180 agency nurses, or .5 %.

It is estimated that the FY 88 cost for contract agency nurses was $8,241,949 or $46,186 per nurse.

CONGRESSMAN HAMMERSCHMIDT

Question: 11. Do you believe that Prosthetic Services is currently understaffed? The DAV on p. 7 of their testimony state that the CMD's Task Force on Prosthetics found that "an additional 83 FTEE are required for marginally acceptable field operations." Do you concur with this assessment?

Answer: The Task Force Report indicated that there was justification to establish 21 additional Prosthetic and Sensory Aids Services. Consideration will be given to funding the 83.4 FTEE identified by the Task Force survey to meet workload requirements for FY 1989. This survey was prior to any curtailment of workload in FY 1989.

Question: 12. The Blinded Veterans Association on p. 3 of their testimony refer to a proposal to establish a pilot program on Computer Evaluation and Training Programs in blind rehabilitation centers. Dr. Gronvall do you support this proposal?

Answer: The Computer Evaluation and Training Program initiative was submitted in 1987 for the 1989 budget. It did not survive the budget process.

With the advancements in technology for the blind, it is essential that the Department of Veterans Affairs evaluate new technology to ascertain its value to blinded veterans in overcoming the handicap of blindness and to train eligible veterans on the use of approved computer technology.

Presently the evaluation of new computer devices and training of Veterans in the use of them is being accomplished at the Blind Rehabilitation Centers detracting somewhat from the "regular" adjustment to blindness program because of the additional workload imposed on the existing staff.

A "special" computer evaluation and training program would allow the department to meet the needs of the blinded veteran by equiping each of the Blind Rehabilitation Centers with the expertise and resources to keep abreast of technology, provide appropriate technology to eligible beneficiaries and accomplish it in a timely and efficient manner.

Question: 13. Dr. Gronvall, a lot of individuals believe that the VA's Prosthetics budget should be a line item so that money intended for this account cannot be diverted to other needs of the medical center. In order to avoid the use of line item budget for Prosthetics, what can or should the VA be doing to protect this important account?

Answer: I believe that we can address this issue administratively. We will issue guidance to Directors of VA medical centers to require that they assign higher funding priority to provide prosthetic services.

Question: 14. On page 2 of your testimony, you state that "significant problems exist with respect to the recruitment and retention of registered nurses... and existing incentives may not be completely adequate to solve these problems." In the same paragraph, you oppose Sec. 101 of HR 901 as being too broad and expensive. What incentives can you identify that will work and you will support?

Answer: We are currently reviewing the results of a VA Nurse Pay Task Force. We would like to complete our review of their findings prior to committing to any major pay reform.

CONGRESSMAN HAMMERSCHMIDT

Question: 15. What statutory authorities other than special pay rates, are you exercising to solve the VA's problems with recruitment and retention of nurses?

Answer: We have made use of the 4107(e)(10) authority which allows the VA to increase the rates of premium pay paid to nurses when necessary to recruit or retain them. We have also made use of the Baylor Plan (4107 (h)) which enables a nurse to work two twelve hour tours of duty between midnight Friday and midnight Sunday and be compensated on the basis of a 40 hour workweek. We have also made use of alternative workweeks, i.e., compressed workweeks, under the authority of 5 U.S.C. 6122. In addition, as another means of enhancing recruitment and retention of nurses, the VA utilizes the authority in 38 U.S.C. 4141 to give scholarships under the VA Health Professional Scholarship Program. Under 38 U.S.C. 4114, as amended by Section 203 of P.L. 99-166, VA now appoints graduate nurse technicians for more than one year, which makes the graduate nurse eligible for health and life insurance benefits immediately upon appointment. This makes the VA more competitive with the private sector. Under this same authority, the VA appoints student nurse technicians while they are still enrolled in nursing school, which assists in meeting patient care needs but also enhances recruitment of students. The requirement in 38 U.S.C. 4112 that the Chief, Nursing Service or designee be included on all policy-making committees is expected to assure that the recruitment and retention issues affecting nurses will receive a high level of attention at each facility.

Question: 16. If implemented and funded, would the increased pay mandated by HR 901 enable the VA to provide competitive compensation to RN's as compared to community hospitals?

Answer: We do not feel that implementation of HR 901 would alleviate the VA's inability to provide competitive rates to nurses now receiving special salary rates (under Section 4107(g)), because special pay under this bill would be offset, dollar for dollar, against existing special salary rates.

Question: 17. You are opposed to Sec. 102 of HR 901 which would provide Saturday Premium Pay to licensed practical nurses and nursing assistants. You state that such mandatory authority is unnecessary since the VA already has discretionary authority to provide Premium Pay to these employees. How many VA hospitals currently exercise this discretionary authority with regard to LPN's and nursing assistants?

You state that the VA is not experiencing a system-wide recruitment and retention problem with these employees. However, the testimony of the American Nurses' Association states on page 4, "VA medical centers report high LPN/LVN vacancies and turnovers, and reductions in LPN/LVN ceilings. The VA cannot employ adequate numbers of LPNs/LVNs because they cannot compete with the private sector." Please respond to this apparent discrepancy.

Answer: VA has discretionary authority to pay LPNs premium pay on the same basis as registered nurses when necessary to recruit and retain them. Once a facility director exercises this discretionary authority, the LPNs would be entitled to Saturday premium pay. There is no authority at the present time under either title 38 or title 5 to pay Saturday premium pay to nursing assistants. Since the authority to affect LPN premium pay has been delegated to the facility directors, we do not have solid data on the number of facilities who have exercised this authority with respect to LPNs.

It appears there has been some confusion on this issue. While the VA is not experiencing a system-wide recruitment and retention problem with nursing assistants, we are experiencing difficulties with the recruitment and retention of licensed practical or vocational nurses.

CONGRESSMAN HAMMERSCHMIDT

Question: 18. Are there any instances that you know of when individuals in the so-called "hybrid" category, who are employed by the VA, are precluded from employment in addition to, but outside of, the VA?

Answer: VA policy does not preclude such employees from accepting employment outside the VA. We are not aware of any instances where local facilities have imposed such a restriction.

Question: 19. Your testimony states that you are unable to support the concept of the VA caring for DOD beneficiaries on a space-available basis because "such arrangement raises numerous unresolved issues." Please elaborate on these unresolved issues.

Answer: The Office of Management and Budget, the Department of Defense, and the Department of Veterans Affairs need to address issues such as dual eligibility of beneficiaries for both the VA and military systems, quality of care requirements, and allowing the Civilian Health Program for the Uniformed Services (CHAMPUS) to pay VAMCs.

Question: 20. You state that the VA's current computer system is capable of producing a list of individuals eligible for CHAMPVA benefits. Would the resulting list be "complete and accurate as mandated by Sec. 303 of HR 901?

Would the list derived from the VA's current computer system satisfy the requirements of the Inspector General provision with respect to compliance with the intention of Sec. 303?

Answer: Yes, our list would meet these requirements.

Department of Medicine and Surgery
Washington D.C. 20420

Veterans Administration

In Reply Refer To:

MAY 0 2 1989

Honorable G. V. "Sonny" Montgomery
Chairman
Committee on Veterans' Affairs
House of Representatives
Washington, DC 20515-6335

Dear Mr. Chairman:

This is in response to the question raised at the House Veterans' Affairs Committee's hearing on April 12, 1989, concerning the approval authority for special salary rates and higher premium pay rates for registered nurses, licensed practical and vocational nurses, and nursing assistants.

The complexity of this issue is caused by differences in pay policies and procedures under the different personnel systems we now operate within Veterans Health Services and Research Administration (VHS&RA). Registered nurses are covered by the Title 38 personnel system. Licensed practical nurses (LPNs) and licensed vocational nurses (LVNs) are among the "hybrid" occupations that are covered by Title 38 for some purposes and the Title 5 competitive service system for others. Nursing assistants are covered solely by the Title 5 system. I regret the confusion that ensued on this issue at the hearing.

For registered nurses, the Chief Medical Director approves special salary rates and medical center directors have discretionary local authority to approve higher rates of premium pay when necessary for recruitment and retention. In addition, all registered nurses receive premium pay for Saturday work pursuant to P.L. 100-322, which made this component of higher premium pay mandatory.

For LPNs and LVNs, the Chief Medical Director approves special salary rates and medical center directors have discretionary local authority to approve higher rates of premium pay, including premium pay for Saturday work, when necessary for recruitment and retention.

For nursing assistants, the Chief Medical Director approves special salary rates, subject to a 90-day review period by the U. S. Office of Personnel Management. There is no authority under Title 5 to pay higher rates of premium pay or premium pay for Saturday work.

I trust that this clarifies the question. Please let me know if you need additional information. An identical letter is being sent to Congressman Morrison.

Sincerely yours,

John A. Gronvall, M.D.
Chief Medical Director

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May 15, 1989

Honorable G.V. (Sonny) Montgomery
U.S. House of Representatives
Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, DC 20515

Dear Congressman Montgomery:

Thank you for the opportunity to respond to the Honorable John Paul Hammerschmidt's May 12, 1989, questions for the record.

The questions posed during the subcommittee on Hospitals and Health Care hearing are answered on the attached pages.

Cordially,

Claudette Morrissey

Claudette Morrissey
President

CM/jl
Enclosures

QUESTIONS SUBMITTED BY THE HONORABLE JOHN PAUL HAMMERSCHMIDT FOR PANEL FOUR

TO: IRENE LUSSIER OF THE ANA AND CLAUDETTE MORRISSEY OF THE NURSES ORGANIZATION OF THE VETERANS ADMINISTRATION

1). Do shortages of allied health professionals (licensed practical nurses, nursing assistants, occupational therapists, physical therapists, laboratory technicians, etc.), contribute to the shortage of registered nurses?

Response - Shortages of allied health professionals do contribute indirectly to the shortage of registered nurses. Lack of allied health professionals increases the workload of the R.N. who is held accountable and responsible for patient care whether it is shared by others or is filled in by the thinly spread "Do Everything for Everybody" R.N., type E.

Staff shortages in other areas means R.N.s are required to do the work of licensed practical nurses, physical therapists, laboratory technicians, radiology technicians, respiratory therapists, ward secretaries and housekeepers. The health industry recognizes the versatility of the R.N. and therefore, the economics of hiring this all purpose employee who can fill in the gaps, when necessary, to accomplish all the jobs related to patient care. Unfortunately, the R.N. cannot do what she does best -- practice nursing. Patients suffer and the profession suffers. This additional frustration, compounded with other deficits currently experienced by R.N.s, contributes to the shortage of R.N.s and all other health care workers.

2). Is there a shortage of allied health professionals in the VA?

Response - Yes; there is a shortage of allied health professions in the VA. We are unable to hire enough licensed practical nurses, physical therapists, laboratory technicians, radiology technicians or respiratory therapists. We cannot keep ward secretaries due to the non-competitive pay.

3). What initiatives can you identify that the VA, on their own authority can and should be implementing to help ease the nursing shortage?

1. The VA should work with OPM to change the standards for grade classification for LPNs and NAs. As the availability of R.N.s decreases, the LPNs and NAs can be given more responsibility for the technical skills, i.e., change standards to permit catherization and suctioning at the GS4 level. The grade levels for these two categories also need to be studied. As they begin taking on more technical skills, there should be a corresponding increase in their grade.

2. The entry level for LPNs and NAs could be upgraded to a GS5 for the LPN and to a GS4 for the NA. The grade range for the LPN to become a GS8 and for the NA to a GS6.

3. At present, agency nurses and fee basis nurses are not included in the cumulative FTE for the medical center. The dollars to pay these individuals come from operation dollars rather than salary dollars. It is recommended that agency nurses and fee basis nurses be included in the cumulative FTE and salary dollars be allotted from salary accounts.

4. Remove the pay cap for overtime pay. The Directors of the local VAMCs should support removing the pay cap for overtime at their individual facilities.

5. Change the procedure for enacting Special Salary Rates in order to expedite implementation and streamline the process.

6. Change the criteria for Specialty Advancements so that more than one step may be given for performance and for assuming a head nurse position.

7. Change within grades raises to every year instead of every two years. In addition, legislative efforts are needed for authorizing premium pay for LPNs and NAs. This legislation failed to pass the 100th Congress.

The VA's study of recruitment and retention mandated by PL 96-330 points the way to solutions to the recruitment and retention difficulties. NOVA wishes to focus on some of the most urgent recommendations.

A. Salaries Competitive with Community Rates

The VA study of recruitment and retention factors found only 54% of the VAs had comparable salaries and that 50% for the facilities were at a disadvantage in providing regularly schedules pay increases. Presently 102 of the 172 facilities use the special salary rates to address the disparity between the VA and the community.

NOVA proposes the following the correct this situation:

1. Revise the present base pay rates for all Title 38 registered nurses. The levels could be improved by making the entry level of Junior grade linked to the GS-7 level, and to avoid severe wage compression and retain experienced nurses, elevate each of the other grades accordingly.
2. Provide bonus or differential pay similar to the physicians bonus to nurses assuming additional responsibilities such as head nurses.
3. Assure that all nurses receive the annual Federal Cost-Of-Living-Adjustment even when they are on special salary rates.
4. Remove the Pay Cap from overtime pay for registered nurses. Currently, no matter what the nurses rate of pay is, the maximum overtime is paid at intermediate step 1.

B. Consistent Support Services

1. Support clinical application of modern technical support, i.e., computerized data entry, unit dose, pharmaceutical delivery, etc.
2. Expand the utilization and employment of ancillary personnel responsible to nurses to assist in the clinical and non-clinical support tasks essential to nursing care.

C. Staffing Levels Based on Workload

1. Identify the staffing guidelines by which the VA abides. Support the staffing numbers that are identified by this method. Adequate staffing is a crucial factor in the quality of care and job satisfaction equation.

D. Innovative projects to enhance Recruitment and Retention

1. Obtain the authority for the VA to hire retired military nurses without retired nurses losing their military retirement benefits.
2. Develop nursing educational outreach programs to corpsmen, paramedics and others with health care training to work for the VA and pursue nursing education.
3. Support the development of a campaign of positive images and education about the positive aspects of working as a VA nurse caring for veteran patients.

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May 15, 1989

Rep. G.V. Sonny Montgomery
Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, D.C. 20515

Dear Rep. Montgomery:

Enclosed are the American Nurses' Association's responses to the following questions as submitted by Representative John Paul Hammerschmidt.

1. Do shortages of allied health professionals (licensed practical nurses, nursing assistants, occupational therapists, physical therapists, laboratory technicians, etc.) contribute to the shortage of registered nurses?

Response: Yes, the shortage of allied health professionals does contribute to the shortage of registered nurses. Nurses want to be nurses. However, shortages of support personnel and allied health professionals usually mean the nurse assumes the functions of missing personnel. Medical centers are unable to fill ward clerk vacancies, which requires the nurse to assume those clerical duties. VA nurses in California are requesting more support staff so they can nurse patients and not answer telephones and process requisition and laboratory forms. Some hospitals have no full pharmacy coverage. On evenings and the weekends, nurses must mix their patients' intravenous medications.

Reductions in housekeeping staff have had an impact on patient care as well. Nursing staff must clean up spills and make discharge beds to ensure patients do not sit in the hall awaiting a bed.

Increased patient acuity and earlier discharges have resulted in a significant increase in the workload per registered nurse. This has created job dissatisfaction. For example, nurses who work in settings where all allocated registered nurse positions cannot be filled are forced to change the way they provide care. They are required to take on an accelerated pace of activities in an effort to stay on top of everything. One alteration in their work style often leads to another; as their workload increases they must set new priorities for the nursing care they give. When nurses have an unrealistic workload, the margin for error increases. Patients may not be monitored as frequently or as thoroughly. Gradual changes signaling the onset of more serious problems may not be immediately recognized. Crisis situations occur that might have been prevented. In addition, psychosocial care, teaching, emotional support and counseling are often omitted. Prividing less than optimal patient care often results in low morale and a sense of dissatisfaction. This exploitation of limited manpower has prompted many nurses to express concern regarding patients' welfare and to question the quality of care being delivered. Ultimately they become exhausted, disillusioned and burned out. Some leave the VA at this point.

2. Is there a shortage of allied health professionals in the VA?

Yes, there is a shortage of allied health professionals in the VA. Many medical centers report high vacancies of licensed practical nurses (LPN). Additionally, the Mid-Atlantic Region has been instructed to reduce LPN/nursing assistant ceilings by 25 because of shortfalls. Pharmacists and respiratory therapists are in short supply, as well.

3. What initiatives can you identify that the VA, on their own authority can and should be implementing to help ease the nursing shortage?

Compensation is a major factor and the VA has the authority to provide special pay, premium pay and bonuses. However, appropriate funds must be appropriated and specifically designated for such application.

Provision of child care, tuition assistance and the availability and opportunity to attend continuing education programs are also recruitment and retention initiatives that attract personnel. Flexible hours and bonuses for twelve hour shifts and weekend schedules permit those in school and with family demands to work. The traditional 40 hour week does not allow part-time workers to earn enough to justify child care, transportation and other costs. The private sector and agencies provide such schedule and salary incentives.

Instead of using outside agency nurses which may cost $250,000 to $500,000 for medical centers, allow the VA to utilize its own nurses by creating a VA pool of nurses. They would make more than overtime, have flexibility in scheduling and accepting of assignments. One of the reasons VA nurses desire changes in "moonlighting" provisions is to allow them to make more money for additional work. Nurses who presently work overtime in the VA have their pay limited by overtime caps. The may also be given "comp" time instead of pay because of budget. However, ironically, the nurse shortage may mean there is no opportunity for them to take the time off especially when they desire it.

Thank you for the opportunity to further address the issue of the nursing shortage. If ANA can be of further assistance please contact me.

Sincerely,

Donna R. Richardson, R.N., J.D.
Director
Congressional and Agency Relations